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The Role of Emotional Discharge in the Resolution of Grief

Anne M. Metzger

THE ROLE OF EMOTIONAL DISCHARGE IN THE RESOLUTION OF GRIEF

by
Anne M. Metzger

Bachelor of Arts, Muskingum College, 1972

Master of Arts, University of North Dakota, 1975

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This Dissertation submitted by Anne M. Metzger in partial fulfillment of the requirements for the Degree of Doctor of Philosophy from the University of North Dakota is hereby approved by the Faculty Advisory Committee under whom the work has been done.

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(Chairman)

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Dean of the Graduate School

Permission

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ABSTRACT

Many authors have expressed the opinion that the resolution of grief requires the open expression of the emotions accompanying grief. While this need for emotional discharge has been mentioned frequently, there has been no empirical evidence of a connection between emotional discharge and successful grief work. This study was designed to investigate the hypothesis that recently bereaved individuals who reported more emotional discharge behaviors would have a more positive resolution of their grief at four months post-bereavement. It was also hypothesized that the specific type of discharge behavior and the number of individuals involved would not be significant. However, it was predicted that in order for emotional expression to be helpful, it would require the aware attention of another individual. Thus discharge which occurred while the bereaved were alone was expected to have no significant contribution to outcome.

In the longitudinal portion of the study, recently bereaved individuals were asked to record discharge behaviors as defined by Jackins (1962). These behaviors were recorded on weekly forms which inquired about situations when the loss was discussed with other people and situations when the individual was alone and thought about the death. Each subject completed the Life Satisfaction Index and Outcome Self-Report Form at 1, 2, 3 and 4 months post-bereavement as an on-going measure of outcome. At the four month interval the Health

Questionnaire and the Social Readjustment Rating Scale were also completed. An open-ended tape recorded interview was conducted to obtain additional information and obtain descriptions of events which had been most and least helpful, changes which had occurred in their feelings, and their reactions to the research project.

In the retrospective portion of the study, individuals who had been bereaved within the past year were asked to rate the degree to which they had displayed emotional discharge behaviors both in individual and interpersonal situations during the time intervals: from the death to 2 weeks, from 2 weeks to 3 months, from 3 months to 6 months, and from 6 months to 1 year. As in the longitudinal portion, the outcome measures were administered and an interview conducted.

Scores for total interpersonal discharge and total discharge while alone were calculated for all subjects. When subjects were dichotomized into high versus low dischargers and good versus poor outcome the Fisher test of exact probability indicated no significant relationship. When subjects were rank ordered on both dimensions a Spearman rank correlation indicated a negative nonsignificant relationship between the amount of emotional discharge reported and positive outcome. There were indications from stepwise forward multiple regression analysis that emotional discharge when alone was a significant predictor of negative outcome.

Consideration of individual case reports suggested that negative outcome was related to feelings of not having anyone with whom to discuss feelings of grief and disappointment in people that had been expected to be helpful. It also appeared that estimation of negative

outcome was more valid at one year post-bereavement than at four months.

Methodological considerations and problems were discussed. Suggestions were made concerning the identification of individuals at risk for pathological grief reaction and possible interventions were suggested.

CHAPTER I

INTRODUCTION AND REVIEW OF THE LITERATURE

As psychology has attempted to understand human behavior, increasing emphasis has been placed on investigating events which are common to most of mankind as well as events which identify the uniqueness of individuals. The experience of grief is one of these universal events which has only recently received scientific attention. Although it is a unique individual who enters adulthood without having faced the death of someone close to them, the investigation of human grieving has been limited in scope. The very universality of grief has made it appear to be an inevitable process of coping with strong emotional reactions until resolution occurs naturally over time. Psychological interest has focused on identifying those individuals who appear to have more than ordinary difficulty dealing with grief, where the emotional resolution appears to be disrupted.

One research approach has been to provide a description of the natural process to use as a comparison in identifying individuals who do not resolve their grief. However, these descriptions focus on what happens, not how it happens. With more complete and consistent descriptions being provided, it is appropriate to turn attention toward an effort to discover how grief is resolved, what emotional "grief work" is necessary. The important question is how do those who resolve their

grief deal differently with their emotional responses than those who do not reach a point of resolution.

The terms bereavement, grief and mourning are all closely associated but need to be clearly defined in a review of the psychological literature. Although authors vary in their use of these terms, for consistency a uniform definition will be maintained here. Bereavement refers to the factual state of having lost a relationship through the death of another individual. Following Averill (1968), bereavement produces two types of response, labeled bereavement behaviors. Grief refers to the internal psychological or physiological events which occur in a bereaved person as a result of their confrontation with the loss. Various explanations and descriptions of grief have been offered and will be reviewed. In fact, a large body of the psychological literature is an attempt to reach a clear definition of what grief is. While grief is an internal process, mourning is the label applied to the external cultural ritual for expression of loss. Funerals, changes in apparel, and limitations of activity are mourning behaviors. Grief may be the universal response to loss by bereavement, while mourning represents the culturally determined differences in the social expression of loss. Responses to loss of any important relationship through job changes, moving, divorce, marriage, or maturity may also be considered occasions for grief (Marris, 1974), but it seems necessary to study bereavement in response to a death to best discover the fundamental grief process and the ways resolution occurs.

Attempts to explain grief as a psychological process usually are traced to Freud's essay, "Mourning and Melancholia" (1917/1963).

Unfortunately an explanation of grief was not actually the aim of his discussion, but served as a comparison for depression. He defined grief as the reaction to the loss of a loved person or idealized concept, being characterized by dejection, loss of interest in the world, loss of capacity to love, and lower activity level. Depression is distinguished from grief by the presence of lower self-regard.

The psychodynamic explanation of grief (Bowlby, 1961b; Freud, 1917/1963) centers on the inability to immediately accept the end of the relationship (object loss). There is an initial attempt to deny the loss by recreating the individual within the griever's mind. However, normal daily events continue to confront the person with the reality of the loss (reality testing) and gradually the energy (libido) invested in the lost relationship is redirected to new people or interests. Freud (1917/1963) notes that he is unable to explain why this reality testing is normally so painful and admits to having no complete explanation of the energy cycle in grief.

The most extensive and recent consideration of dynamic theoretical views has been made by John Bowlby (1961a, 1961b, 1973; Bowlby & Parkes, 1970). Taking issue with some of the more traditional interpretations, Bowlby has based his interpretation of grief on his theory of attachment and separation. Bowlby traces human grief responses from adaptive, instinctual, biological responses to separation from a person to which an individual has been attached. This response is also seen in a variety of animal species. Normally, separation produces a protest and search which leads to a reunion with the lost figure; statistically,

it is rare that this reunion is impossible because of the death of the lost person.

In 1961 Bowlby identified three stages of mourning or grief. (He has changed his use of these terms since then and now uses grief as defined in this review.) The initial stage is characterized by the urge to recover the lost individual, displayed by anger and weeping. Bowlby explains that the separation is a stimulus for instinctual systems focused on recovery. Since these systems are still focused on the original object, which is permanently gone, there is no terminating stimulus. Thus the prolonged weeping and anger of grief is produced by the yearning and attempt to be reunited. The second stage of grief is characterized by disorganization of personality as the connection between instinctual patterns and the missing person is extinguished. Bowlby describes depression as inevitable since the hope of recovery is also extinguished. Finally, a third stage occurs in which there is some reorganization, considered the end of the grief process. More recently (Bowlby & Parkes, 1970) a fourth stage has been described, an initial period of shock and numbness which may last as long as a week before the attempt to recover is begun. Thus Bowlby views the human experience of grief as an instinctual response to a biological disequilibrium that has been produced by a sudden change in the environment.

Bowlby's writing (1961b; Bowlby & Parkes, 1970) has stressed the need for the instinctual pattern to be expressed in order for the resolution of grief to occur through extinction of the tie between object and response. Unfortunately, the expression of this attachment is often considered socially unacceptable, especially for adults. Bowlby

stresses that the attachment itself and the emotional expression following loss is a normal and healthy part of instinctual behavior. He suggests that adults need the help of a trusted person who can give them the safety to express all their feelings--abandonment, yearning, and anger--even though their thoughts may appear irrational and illogical.

In 1968 Averill reviewed the available literature on grief and arrived at somewhat different conclusions than Bowlby. While agreeing that grief is the product of biological evolution, Averill concludes that its adaptive function lies with the social group rather than the individual. He argues that grief behaviors don't serve the individual's need, often retarding the formation of new relationships and hindering a break with the past. However, the pain of grief may be justified by serving the evolutionary demands of a species which is dependent upon social behavior for survival. Thus grief may punish the isolated individual and promote group cohesiveness.

Averill also differs from Bowlby in concluding that the emotional responses of anger, anxiety, and guilt are not essential components of the grief reaction. Rather they arise from specific situational factors which may or may not be present. Anger is explained as a result of frustration with the loss and may also be chosen as a form of defense against the painful feelings of grief. Anxiety may occur to the degree to which some hope exists, but is not a part of grief. Separation anxiety is conceptualized as distinct and qualitatively different from common forms of anxiety. Finally guilt is explained as a solution to the cognitive dissonance which occurs when a strong, unexpected, emotional reaction such as grief occurs. The deceased may be idealized or

the survivor subjected to self-condemnation in order to provide a rationale for the pain of grief. Thus guilt may be caused by depression and pain, rather than guilt giving rise to depression. Averill's position focuses on grief's societal function and does not assume any need for the outward expression of strong emotions to produce a resolution. As long as internal pain existed its evolutionary function would be maintained.

A broad view of grief has been incorporated by Jackins (1965) into a basic model of human behavior. Jackins assumes that when people experience loss and hurt they will naturally react with a discharge of emotion which ends the psychological or physical pain. This discharge occurs naturally in infants and young children but is gradually limited by social norms and expectations, until by adulthood there are few socially approved ways to release emotional tension. This view parallels Bowlby's description of the disapproval adults receive for the expression of yearning when attachment is disrupted. However, Jackins includes a wide range of behaviors which can serve a discharge function, ranging from laughter and rapid talking to crying, sobbing, and violent movements. Jackins' theory implies that grief would be resolved through the discharge or expression of the emotions that accompany the loss, a process which would occur naturally if not inhibited by social expectations. Thus the bereaved who experience more emotional discharge should reach some level of resolution sooner than those who experience little or no discharge.

The model predicts that if people were completely able to discharge their distress they would be able to creatively utilize all their

intelligence in any given situation. Instead, most people are not able to discharge and experience distress or "restimulation" in situations which are similar to those in which they were originally hurt. Jackins' procedure for promoting discharge (re-evaluation counseling) requires the same situation which Bowlby describes, the attention of a safe listener which permits the expression of the emotional discharge.

While theoretical explanations of grief and its resolution have drawn on observational or descriptive studies, these studies have usually not been guided by a particular theory. Psychological investigations have generally focused on one of two questions: (a) What relationship does grief have to behavior pathology and traditional psychiatric diagnostic categories? (b) Can variables be identified which predict a negative resolution of the grief process? Another group of more sociologically oriented research has addressed the issue of how grief effects individuals as members of a group, particularly their redefinition of roles and their systems of social support. Both the psychological and sociological research will be reviewed.

The Relationship of Grief to Behavior Pathology

The potential for unresolved grief, considered a negative outcome, was mentioned in the literature as early as Freud's description (1917/1963). Generally theorists describe negative outcomes as the result of a halting of the grief process, leaving it incomplete. Lindemann (1944; Cobb & Lindemann, 1943) is credited with the first comprehensive description of what he termed "acute" and "morbid" grief reactions. While his conclusions were based on only the observational data

of psychiatric interviews with 101 patients, they drew attention to the possibility of grief providing an explanation for pathological behaviors.

Lindemann (1944) described grief as a specific syndrome with both psychological and somatic symptoms, distinctively characterized by somatic distress, preoccupation with the image of the deceased, guilt, hostility, and loss of normal patterns of behavior. He is perhaps best known for his identification of morbid grief reactions, which he classified as either delayed or distorted. Delayed responses are characterized by a postponement of any response of grief, while distorted responses are characterized by nine patterns: overactivity without a sense of loss, acquiring the symptoms of the deceased's illness, medical disease, change in relationships to friends and relatives, hostility toward specific people, affect resembling schizophrenia, loss of patterns of social interaction, activity detrimental to own social and economic existence, and agitated depression.

Lindemann suggests an intervention of eight to ten psychiatric interviews over a course of four to six weeks to settle uncomplicated and undistorted grief reactions. His implication appears to be that if this intervention is prompt, there will be no opportunity for morbid reactions to develop. The aim of the interviews is to help the griever with what Lindemann termed "grief work." Grief work involves accepting the pain of bereavement, reviewing the relationship with the deceased, and realizing an altered pattern of emotional reaction exists. Fears of insanity, changes in feelings, hostility, and guilt need to be worked through, enabling an expression of sorrow and loss. This should result in some new conceptualization of their relationship to the deceased and

the acquisition of new patterns of conduct. In general, this therapy description is typical of psychoanalytic approaches to therapy involving grief resolution.

Although Lindemann's work pointed toward the potentially negative outcome of grief, there was no statistical data base as a test of his conclusions. In the early 1960's Colin Murray Parkes, at the Tavistock Institute in London, began an extended study of grief. Initially (Parkes, 1964a, 1964b) he established a significant relationship between bereavement and physical and mental health. One investigation examined whether bereavement had occurred in the pre-illness history of hospitalized psychiatric patients at more than chance levels (Parkes, 1964b). Data from the case notes of 3,245 patients seen from 1949 to 1951 were included. In 2.9% of the cases the presenting illness had occurred within six months of bereavement. Assuming that bereavement rates were equal in both the hospitalized population and the general population, there were significantly more bereaved women over 40 among the hospital population and significantly more patients who had lost a spouse than would have been predicted by the general population bereavement rates.

Another study used 44 widows as their own controls in comparing their medical records two years before bereavement with their records 1½ years post bereavement (Parkes, 1964a). Grouping data into six month blocks, there were significantly fewer consultations across the control period as compared overall to the post bereavement periods. The increase in the number of psychiatric consultations (as opposed to medical) was significant for widows under 65 years old, but not for those over 65. When all nonpsychiatric consultations were grouped together

there was a significant pre- vs. post-bereavement difference, with no significant age difference. Parkes concludes that bereavement produced significant mental and physical health consequences which justified further psychological investigation.

Another group of studies at Washington University in St. Louis has also examined the psychological result of bereavement, but has done so by comparing the bereaved to traditional diagnostic categories. A checklist of symptoms for depression, anxiety neurosis, alcoholism, schizophrenia, and acute brain syndrome was used in interviews with relatives of 30 patients who died (Clayton, Desmarais & Winokur, 1968). Initial interviews were conducted 2 to 26 days after the death and followup interviews at one to four months. Initially more than half the relatives showed symptoms of depressed mood, sleep disturbance, and crying. At the followup 81% had improved and 98% had not sought psychiatric assistance. The authors criticize studies following Parkes' model in which subjects are selected through some existing medical contact, which they believe creates a biased sample.

A later study (Clayton, Halikas & Maurice, 1972) of 109 widows and widowers, randomly selected from obituaries and death certificate records, identified 22 as definitely depressed and 16 as probably depressed. Comparison of these two combined groups to the non-depressed bereaved revealed that the groups were distinguished by the depressed having no children in the immediate geographical area. A followup of this subject group (Bornstein, Clayton, Halikas, Maurice & Robins, 1973) at 12 months after bereavement indicated that the best predictor of depression at one year after bereavement was the presence of

depression at one month. The authors conclude that grief is not a model for psychotic depression, and should not be grouped with affective disorders.

Stressing this distinction, a direct comparison of this bereaved sample and patients diagnosed as having primary affective disorder was made (Clayton, Herjanic, Murphy & Woodruff, 1974). A smaller subset of the two groups of subjects was also compared, matched for age and sex. On the matched groups a comparison of frequencies of psychiatric symptoms showed that the depressed had more symptoms than the bereaved. However, on the basis of specific types of symptoms the bereaved could not be clearly differentiated and a need for more precise guidelines for diagnosis was noted. The authors also point out that the responses of the bereaved may be labeled as "normal" by both themselves and their environment, while those with primary affective disorder label themselves as "changed" and seek psychiatric help.

An additional comparison of this sample of bereaved subjects was made with a sample of psychiatric inpatients diagnosed as depressed and a sample of divorced subjects (Briscoe & Smith, 1975). Subsets matched for age and sex were compared on the basis of history of previous depression, incidence of psychiatric illness in their family, and the depressive symptoms present at onset of their current status. The authors conclude that bereavement is separate from both depression and divorce, while depression and divorce may be grouped together.

The Parkes and Clayton studies do not agree in their approach to data collection, but both seem to conclude that grief is a disruptive psychological process worth further attempts at explanation and analysis.

Jacobs and Ostfeld (1977) have recently reviewed studies published in the past 17 years which reported increased mortality in survivors of conjugal bereavement. They conclude that an elevated mortality risk does, in fact, exist in conjugal bereavement. The data reviewed indicate that men are at greater risk at all ages, with the greatest effect in the first six months after the death. Younger women are more at risk than older women, and the effect of increased mortality extends across two years after bereavement. Jacobs and Ostfeld stress that there is strong evidence that psychological factors have an effect on physical health, making bereavement an important area of investigation.

Early Sociological Research

Early research attempts also included survey methods with a more sociological emphasis. Marris (1958) surveyed a group of working class London widows whose husbands had been under 50 years old at the time of death. In addition to asking about the widows' emotional reactions to bereavement, he also examined financial and social problems arising after bereavement and the role that immediate family members and other relatives had in finding solutions.

He identified four main forms of grief reactions: physical symptoms, loss of contact with reality, a tendency to withdraw from others, and hostility. He viewed his findings as compatible with the description provided by Lindemann (1944). Marris interpreted mourning activities as an expression of a basic psychological ambivalence toward the loss of the deceased and noted that many widows needed permission

from family or friends before ending the official mourning period. This research appears to have been conducted during a transition in the social expectations for official mourning, 90% of the widows over 40 wore mourning clothes more than three months while only 64% of younger widows did so.

Marris concluded that it often took two years or more for a widow to become reconciled to the loss, and that the best aid to recovery was the reassurance that she had mourned enough.

Gorer (1965) also used survey methods to identify sociological and cultural implications of bereavement in an English sample. Gorer focused more on mourning patterns than on grief and formed conclusions also generally congruent with Lindemann's (1944) descriptions. He identified eight different styles of mourning which appeared to fit with normal or morbid grief reactions and described intense mourning as lasting from 6 to 12 weeks. Gorer also attempted to identify patterns of role behaviors adopted in response to specific types of bereavement, such as death of a parent, spouse, or sibling. He concluded that the ritual expression of mourning served an important function by providing a socially acceptable expression of grief, noting that the bereaved who had no mourning custom were experiencing more difficulty. He stressed that the majority of his sample had followed no structured expression of mourning and had made little progress toward resolution; the societal trend toward a rejection of ritual having continued since Marris' (1958) study. Gorer presented Bowlby's stages of grief and agreed that it is important for the bereaved to express emotional reactions, concluding

"the ability to weep freely and admit doing so seems a reliable sign that mourning is being worked through and overcome" (Gorer, 1965, p. 82).

Recent Investigations

Recent trends in grief research have been to consider a longitudinal perspective and use a structured interview methodology. An extended time frame has been used to permit closer examination of grief as a process producing change for an extended length of time and to examine descriptions such as Lindemann's and Gorer's which view grief as a relatively brief process. This more recent research combines the general sociological question of how bereavement affects the organization of a person's life with psychological attempts to describe the normal course of grief.

In 1970 Parkes published a report of a longitudinal study of 22 London widows under 65 years old which spanned the first 13 months of bereavement. Extensive interviews were held with each woman at approximately 1, 3, 6, 9 and 13 months of bereavement. The initial interview was designed to obtain information about the terminal illness, the circumstances of the death, her reactions from the time of the illness to the present, and her current life situation and family history. Later interviews focused on events and reactions occurring since the previous interview and elicited information to allow the interviewer to complete a checklist of psychological symptoms. At the final interview ratings were made of psychological, social and physical adjustment.

The descriptive statistics used present a complex picture of grief which is difficult to summarize. In general the data support the Bowlby and Parkes (1970) description of general stages, but do indicate that phases are not distinct or isolated. A general numbness and disbelief was widespread and for some lasted as much as one month. The phase of yearning and protest was characterized by preoccupation with thoughts of the deceased accompanied by increasing vividness of memory, attention directed toward places and objects associated with the deceased, a tendency to misperceive and feel the deceased to be present, and crying for the lost person. The presence of these characteristics was positively intercorrelated, leading to the conclusion that they represent a single process. Anger and guilt were associated with each other, but anger also occurred independently. Searching appeared to be a continuous state while anger did not. Numbness lasted up to a week for most women, followed by protest which peaked at two to four weeks. General disorganization continued for many widows the entire period of the study.

Parkes points out that there was a significant negative correlation between overall affect in the first week and that in the third month. He argues that this strongly supports the idea that expression of the grief soon after bereavement permits the beginning of recovery, while restraining affective expression only delays and produces potentially more severe disturbance. A variety of both self-report and interviewer ratings of outcomes were made including overall social adjustment, view of the past with pleasure and the future with optimism, general health, level of contentment, and level of adjustment. In each

rating there was a wide range of outcomes; unfortunately there is no indication if the widows who were rated poorly on one dimension were also rated poorly on others. The interviewer's ratings of adjustment at 13 months concluded that 3 were very poorly adjusted, 9 intermittently disturbed and depressed, 6 had tenuous adjustment and 4 good adjustment.

Another extended, longitudinal study was conducted at the Harvard Laboratory of Community Psychiatry with Parkes serving as a member of the research team. This study, perhaps more than others, had a clear orientation toward preventive community psychiatry. Early working papers of the project (Baler & Golde, 1964; Caplan, 1964) explain that the community model assumes that mental health problems often stem from unhealthy life adjustment. These problems may be altered in a wide variety of ways by both the sufferer and the social network in order to establish relationships which will provide a healthier equilibrium.

The Harvard Bereavement Study was based on three main hypotheses (Baler & Golde, 1964). First, in comparison with the married, the widowed have a significantly higher risk of mental disorders and psychosomatic illness; this hypothesis was considered already supported by epidemiological data. Second, there is a significant relationship between mental and physical health outcome and the patterns of coping used in response to the intrapsychic and external reality demands imposed by the loss of a spouse. Third, the excess risk of mental disorders and psychosomatic illness among the widowed can be significantly reduced by preventive intervention that specifically modifies coping behaviors.

The study included 49 widows and 19 widowers under age 45, approximately 20% of that aged population widowed during the sampling period. Structured, open ended, tape recorded interviews were conducted by social workers at 3 weeks, 8 weeks, and 13 months after bereavement. Followup was conducted two years after all original data was collected, making followup data range from two to four years after the actual bereavement.

In a report published before the full project report, psychological and physical outcome data for the bereaved group was compared to a control sample matched for sex, age, precinct of dwelling, family size, nationality, and occupational class of spouse and respondent (Parkes & Brown, 1972). This data was collected at a 14 month post-bereavement interview conducted by graduate students uninformed of the previous year's study. A forced choice questionnaire form was used. A factor analysis of 218 questions concerning symptoms and attitudes yielded six factors permitting derivation of scores for depression, external anxiety, compulsive self-reliance, autonomic reactions, stimulus seeking, and interpersonal fear. Using "common sense methods" scores were also formed for general irritability, paranoid attitude, self-esteem, authoritarianism, rigidity, emotionality, psychosocial functioning, and acute and chronic physical symptoms. This second group of scores did contain some overlap with the factorially derived scores.

When compared with the control groups on the data gathered at 14 months bereavement, the widowed group had significantly more days sick in bed, more hospital admissions, more disturbance of sleep, appetite, and weight, increased consumption of alcohol, tobacco, and tranquilizers,

had sought more help for emotional problems, had more evidence of depression, restlessness, and difficulty making decisions, and had a greater sense of strain. However, when the two to four year followup data is the basis of comparison, all differences drop out, except that widowers continued to be more depressed than married men. Examining single items which continued to discriminate groups, Parkes and Brown conclude that there

> . . . emerges a picture of a group who have now become independent and used to being alone. They care little for the opinions of others, worry less than they used to and do not take things hard. Experience has taught them it is safer not to fall in love but they tend to feel apart and remote in company. A significant minority regard their memory as poor and a similar proportion prefer to go out by themselves.
>
> There is nothing in these findings to suggest that a permanent deficit in physical or mental health occurs in a significant proportion of widows or widowers. (Parkes & Brown, 1972, p. 457)

The extended project report (Glick, Weiss & Parkes, 1974) was essentially descriptive in nature, focusing mainly on the widows because of the statistically small sample of widowers. Initially there was a period of shock and disbelief which was accompanied by attempts to inhibit affect and maintain self control, apparently similar to the phase of numbness described earlier. Obsessional review of events surrounding the loss and memories of the deceased then occurred and appear to reflect protest and yearning.

For widows, life organization at the followup had taken two main forms, remarriage or other forms of interpersonal relationship. The other forms were classified as intimate nonmarital relationship, close relationship with one or more relatives, or independence from close relationship with other adults. The only factor which appeared predictive of final life organization was whether or not the widow had

anticipated the death of her husband. Those who had a longer time to anticipate the death most often remarried. Where death was unanticipated the widow frequently expressed fears of again losing a spouse.

Widowers generally tended to talk less with others about their loss. While they stabilized life organization more quickly, the authors note this did not equal emotional recovery. Again, failure to anticipate the death correlated with more difficult resolution. A higher percentage of widowers remarried, but this appeared to be due to pragmatic need for specific resources such as child care or housekeeping.

A later report of the same study (Parkes, 1975) provides a more complete description of outcomes. Parkes reports that derived "outcome" measures (based on the first three interviews and not further described) permitted discrimination of good vs. bad outcome groups. The seven variables contributing the most to prediction of a negative outcome were a negative subjective rating by the data coders, the presence of yearning at three to four weeks, a welcoming attitude toward their own death, a very brief duration of the terminal illness, lower socioeconomic status, the presence of anger at three to four weeks, and the presence of self-reproach at three to four weeks. A "combined outcome" measure indicated that, like future life organization, positive outcome was best predicted by a longer length of time the survivor had had to prepare themself for the death. Concluding that both duration of illness and the duration of actual termination were important, 24 subjects were categorized as the Short Preparation Group, having had less than two weeks warning that the spouse's condition was fatal and/or less than three days warning that death was imminent. The remaining subjects were

categorized as the Long Preparation Group. Since sex was uncorrelated with outcome, both widows and widowers were combined in this analysis.

When the 13 month and two to four year followup data are used to compare these groups, persisting differences are apparent. Only 13% of the Short Preparation Group were rated as good outcome at 13 months, which dropped to 6% at followup. The Long Preparation Group had 60% rated as good at 13 months and 65% at followup. At two to four years only one of the Short Preparation Group had remarried while 11 of the Long Preparation Group had done so. At this time 72% of the Short Preparation Group had difficulty performing their job, 81% had financial problems, and only 25% had a positive attitude toward the future. For the same areas the Long Preparation Group had 34%, 29% and 66% respectively.

Parkes reports that grief had a different pattern for the Short Preparation Group. They were more emotionally disturbed, more anxious, and experienced more guilt and self-reproach. In general they experienced intense shock followed by severe separation anxiety and confused feelings of anger and guilt. On the other hand the Long Preparation Group showed almost no guilt or anger as well as having generally less severe reactions. Parkes notes that this distinction based upon sudden bereavement was not found by Bornstein et al. (1973), but feels the significance is due to the limited age range of the Harvard Study, as compared to the older ages of the St. Louis study. Thus he concludes that the reaction of the Short Preparation Group was produced by deaths which were untimely as well as sudden.

In attempting to explain why the Short Preparation Group is still struggling with grief two to four years after bereavement, Parkes hypothesizes that the searching and protest fail to undergo extinction. He suggests that the griever's defense mechanisms allow a pretense that bereavement has not occurred by avoiding a confrontation with reality situations reminiscent of the loss and by producing an illusory feeling of reunion.

The project report (Glick et al., 1974) concludes that the best overall predictor of failure to recover from grief is a failure to make any progress toward recovery in the first year. However, the normal course of grief saw only initial progress being made in one year and disorganization lasting to some extent until long-term followup. In his foreword to the project report, Gerald Caplan notes that these results have produced two changes in the community theory approach to grief. Bereavement had been considered a crisis to be resolved in four to six weeks, but unlike Lindemann's original conceptualization, grief and mourning may require psychological work for the rest of the survivor's life. A second theoretical implication of this project is that many reactions previously considered unhealthy are normal and have benign predictive significance. Caplan suggests that the future role of community mental health should be to provide the bereaved with some idea of the wide range of responses they may have to mobilize emotional supports at times when the bereaved feel need of them.

This project did not clearly indicate what types of support do permit the bereaved to make some recovery during the first year. Another attempt to address this question looked at how widows perceived

the environmental support available to them (Maddison & Walker, 1967). One hundred thirty-two widows of men between the ages 45 and 60 were asked at 13 months bereavement to rate their behavior during the preceding year. This subjective self-evaluation yielded a health deterioration score which was used to divide the group into "bad outcome" (21.2%), "good outcome" (43.2%), and "indeterminate" (35.6%) subgroups. Twenty of the bad and good outcome widows were matched for religion, socioeconomic status, length of warning of death, and age and then given extensive interviews. One goal of the interview was to obtain information about specific people who were available during bereavement and the widow's perception of their helpfulness. The second goal was to discover what specific forms of interaction the widow had had, whether they were seen as helpful, and whether she had felt a need for this type of interaction. Forms of interaction were categorized as expression of affect, review of the past, orientation toward the present and future, and provision of concomitant needs. In addition to a non-directed interview, a specific list of 59 statements regarding interactions was used to conclude the interview and insure uniform content.

Data regarding specific persons available was not completely analyzed due to the small number of subjects. The most important distinction in the forms of interaction was the occurrence of a greater number of non-helpful interactions for the poor outcome group (Maddison & Raphael, 1975). While both groups felt they had obtained a great deal of help in early interactions, the bad outcome group more often felt people opposed the expression of affect and forced them to avoid focusing on the past or discussing the death. In addition, the bad outcome

group expressed a greater need for these opportunities. While friends were involved in almost half the unhelpful interactions, family members also contributed to these experiences. The widow's own mother was involved in 6.1% of all interactions, but was involved in 7.9% of the unhelpful ones. Thus those closest to the bereaved often appear to be unable to provide the support which the bereaved perceive themselves as needing. It appears that when the length of time permitting preparation of death is controlled, in this case by matching, outcome differences may depend upon external emotional support systems available to the bereaved.

Maddison and Raphael (1975) have identified additional sources of variance in predicting poor outcome. They report that these additional criteria, when used in conjunction with interpersonal transactions in a prospective study, have identified a group of whom 80% have a bad outcome. These additional criteria are the presence of concurrent crisis situations, a mode of death which maximizes anger, guilt, or self-reproach in the widow, and a preexisting pathological marital relationship. Maddison and Raphael support the idea of strengthening the social network of the bereaved, noting that casual attempts to do so may do more harm than good. However, they also emphasize that widows with the predictive criteria of bad outcome need more than brief contact with a general social support system.

Several longitudinal projects have recently reported a part of their data while other analyses are yet to be completed. One such preliminary publication reported data from interviews with 45 bereaved individuals: 20 spouses, 12 children, 6 siblings, 3 parents, 2 other

relatives, and 2 friends (Schwab, Chalmers, Conroy, Farris & Markush, 1975). Two hundred sixty-five interview items yielded data on demographic variables of both deceased and respondent, physical and mental health, social functioning of deceased, life events of deceased, health care and death related facts, and grief reactions. Grief reactions of the bereaved were rated as intense, moderate, or minimal. Significantly more spouses and parents experienced intense grief, as did the survivors where the illness of the deceased lasted more than a year. No significant relationship was found between intensity of grief and the time the respondent was aware of impending death, nor the time between the death and the interview. These results contrast with those of the Harvard Study where awareness appeared more predictive of the grief process than actual length of illness. However, the populations differed considerably; the Harvard Study was limited to spouses under 45 while Schwab et al. included a variety of relationships and ages. Both studies do note that frequently intense grief reactions continue a year after bereavement.

Interventions in the Grief Process

One major research project which also is only partially reported in the literature involved an experimental intervention as well as a description of the general grief process. Conducted at the Montefiore Hospital and Medical Center in New York, the project has only published the results involving medical outcome variables (Battin, Arkin, Gerber & Wiener, 1975; Gerber, Wiener, Battin & Arkin, 1975; Wiener, Gerber, Battin & Arkin, 1975).

The investigation involved random assignment of families with bereavement to a treatment group (T) which was offered psychotherapy for six months, or a non-treatment group (NT) which had no intervention offered. An additional non-bereaved matched control group (NB) was formed of families who had had no death in the previous three years. Interviews using eight questionnaires covering medical, psychological, and social variables were conducted at 2, 5, 8, and 15 months post bereavement, the NB group was interviewed at the same time intervals. Since 70% of the subjects were over age 60, the results are considered pertinent to the aged bereaved.

Medical outcome criteria (office visits, major illness, minor illness, use of medications, use of psychic medications, use of general medications, not feeling well but no physician contact) were compared between the NT and NB groups, providing a description of aged bereavement in general (Wiener et al., 1975). The authors conclude that medical effects for the elderly may be delayed as much as six months. Between five to eight months bereavement there are significantly more physician visits and use of medications than in the control group; bereaved with poor prior medical history have significantly more physician visits in the entire first 15 months. In general, women over 60, especially Jewish women, showed significant medical morbidity.

The intervention used with the T group was first offered by the family physician. Whether or not accepted, a psychiatric social worker called and reoffered assistance, actively trying to enlist participation. An acceptance rate of 94% was obtained to participate in weekly contact. The treatment plan included eight points: permit and guide

expression of affects, help acknowledge the existence of and understanding of emotional reactions, help find acceptable formulation for future relationship to the deceased, act as a primer or programmer of activities, help deal with reality situations, mediate referrals to physician, offer assistance with future plans, and avoid interpretation of defenses or unconscious trends as well as excess solicitude or over protection (Battin et al., 1975). Using the medical outcome criteria the authors report that 75% of the measures suggested that brief therapy was medically beneficial (Gerber et al., 1975). Differences in outcome do not appear until after the third month of intervention and do not appear as strongly for the female Jewish bereaved.

This project does describe a more negative effect of bereavement than the Harvard Study. Coping styles of the T group are categorized as complainer, manipulator, pseudo-independent, dependent, independent, constructive, and accepting-resigned (Battin et al., 1975). They also describe a traditional crisis intervention model without addressing the issue of the extended duration of grief processes (Gerber et al., 1975).

The Montefiore Study introduces a specific approach to psychological intervention with the bereaved. It is a rather unique study in attempting to empirically test an intervention with the bereaved using both an experimental and control group. Other specific interventions have been used, but without controlled evaluations.

Twycross (1976) reports that families of 1,515 patients dying at St. Christopher's Hospice were rated as having imperative need (6%), high risk (19%), or low risk (75%). All of the imperative need and half the high risk group had followup visits from staff members at about two

weeks bereavement. Other visits and assistance provided someone with whom feelings could be expressed, a link to specialized help, and an assessment of the risk of suicide. Fifty-six research interviews were completed using the Harvard Study Health Questionnaire after 18 to 24 months bereavement. Twycross concludes that although the predictive ratings were not highly reliable, they produced few false negatives, 77% of the poor outcome group were correctly predicted to be high risk, while only 23% (n = 4) were incorrectly identified as low risk. The effectiveness of the intervention was not evaluated.

A non-professional intervention with widows was attempted through the Harvard Laboratory of Community Psychiatry, simultaneously with the Bereavement Study (Silverman, 1976). Known as the widow-to-widow program, five volunteer widows offered their experience to new widows of untimely death in young families. The emphasis was on establishing a personal relationship, with the volunteer providing knowledge of concrete services, financial arrangements, or merely advice. Young widows appear to be quite capable of caring for themselves, but need to be able to talk freely and have a nonjudgmental person to listen and sometimes cry on. The program has also provided group meetings for both widows who have not participated individually in the program as well as for those who have personal visits from another widow.

Volkan (1966, 1970, 1971, 1972, 1975; Volkan, Cilluffo & Sarvay, 1975; Volkan & Showalter, 1968) has outlined a psychiatric "re-grief" therapy for "pathological mourners" who continue to search for reunion at six months after the death. Volkan's definition of pathological search and yearning appears to call for more disruption of daily

activity than typical mourning described by Bowlby and Parkes (1970). Volkan originally described an inpatient therapy consisting of three months of daily sessions, with treatment forming three stages (Volkan & Showalter, 1968). Later the hospital emphasis and strict order of the therapy stages was reduced (Volkan, 1971). The therapy does continue to focus on demarcation, forcing the client to verbalize a boundary between themself and the deceased; externalization, talking about the meaning of experiences with the deceased; and reorganization, directing energy toward new relationships.

Based on traditional psychoanalytic theory, re-grief therapy emphasizes the ambivalence the griever feels toward the deceased and the continued introjected presence of the deceased within the pathological mourner (Volkan, 1966, 1971; Volkan & Showalter, 1968). By asking the griever to describe themself and the deceased, often with a photograph present, a confrontation with the fantasized relationship occurs and forces reality testing. Expressions of anger and guilt are encouraged as well as general emotional discharge as the death and funeral are described. Volkan identifies "linking objects" which serve as a symbol of the deceased to the survivor and often asks bereaved clients to deal with the actual object during sessions (Volkan, 1972). MMPI changes have been cited to support the effectiveness of re-grief therapy, but no use of a control group has been reported (Volkan et al., 1975).

Volkan's therapy fits the cathartic therapy model of traditional psychoanalytic treatment of neuroses. Cathartic therapy involves a client recalling the original source of emotional reaction and redescribing

it. This retelling is frequently accompanied by abreaction, or emotional discharge, such as crying or shouting.

Ramsey (Ramsey, Note 1; Ramsey & Happé, Note 2) has also used a therapy technique which promotes emotional responses in treating individuals who have extended or delayed grief reactions. However, he does not use a psychodynamic explanation, but conceptualizes his therapy in terms of behavioral learning theory.

The depression of grief is seen as a consequence of losing a major portion of positive social reinforcers. The individual will usually come to feel that his behavior is unable to control the stress, which leads to learned helplessness or active avoidance of the emotional responses of grief. Unresolved grief is thus viewed as paralleling phobic reactions; the loss produces strong negative emotions which are avoided and then have no opportunity to be extinguished. Ramsey suggests that the most appropriate treatment for severe grief reactions in emotional flooding and prolonged exposure to the stimuli which arouse the negative emotions. The therapist repeatedly confronts the client with the fact of the loss and when an emotional reaction occurs it is allowed to be expressed. This process is repeated until talking about the death and accompanying loss produces no emotional expression in the client. Ramsey states that many clients may be helped to reach Bowlby's stage of reorganization in three weeks. It should be noted that these individuals have had severe grief reactions extending over a year; Ramsey does not suggest attempting to shorten the normal grief process.

Ramsey views his therapy as a guided and systematic form of abreaction which is used to lead to extinction. He takes specific

exception to Volkan's view (Volkan et al., 1976) that psychodynamic training of the therapist and interpretation are important aspects of therapy.

Previous Discussions of the Role of Emotional Discharge

The implied value of some form of catharsis and abreaction appears as a continuing thread in a major portion of the grief literature. There is a consistent reference to the expression of emotional reaction, or discharge, as an important, healthy, and very necessary part of grief.

Of the theoretical accounts, Jackins (1962, 1965) presents the most comprehensive description of the need for emotional discharge. Griefs or losses are the most severe hurts people experience. However, discharging or expressing the emotional reaction permits the grief reaction to pass.

> These processes (discharge) undo the effects of hurts immediately after the hurts happen, they remove the stored distresses immediately after they occur whenever they are allowed to work (italics in the original). (Jackins, 1965, p. 75)

Jackins' is well aware of the societal limitations which inhibit emotional expressions. As noted earlier, it requires the safe attention of another person to initiate the discharge process.

Jackins' model relies heavily on the catharsis and abreaction process. Rather than a single cathartic experience, Jackins' counseling model anticipates asking the client to focus again and again on their loss and to discharge on many occasions. As more of the hurt is

released, the mode of emotional expression may change from the crying most frequently associated with grief.

> The damage repair processes are specific in character, dependably characterized by the outward manifestations of 1) crying, 2) trembling, 3) laughing, 4) anger discharge, 5) yawning and 6) interested, nonrepetitive talking. (Jackins, 1965, p. 93)

Thus all these behaviors, when viewed through Jackins' definition of discharge, may be seen as part of a cathartic model.

Bowlby also suggests that emotional expression is an essential part of grief work. Bowlby and Parkes (1970) describe similar emotional discharge which they believe should be encouraged.

> Yearning for the impossible, intemperate anger, impotent weeping, horror at the prospect of loneliness, pitiful pleading for sympathy and support--these are the feelings that a bereaved person needs to express, and sometimes first discover, if he is to make progress. (Bowlby & Parkes, 1970, p. 210).

Freud's writing is less direct about the role of discharge in working through grief. His early therapy focused on catharsis, but later catharsis became a tangential aspect of psychoanalysis. The problem in interpreting Freud's view is that he considered grief a natural event, resolved without therapy interventions. Thus, generalizing from his therapy approach may not be appropriate. One point which Freud (1917/1963) did raise was that grief work involved confronting each bit of reality individually. This might produce emotional discharge at the level Jackins discusses, without meeting the traditional psychodynamic definitions of catharsis and abreaction.

Averill (1968) is the only one of the theorists discussed who clearly views the expression of external emotion as secondary to the function of grief. He clearly would not support the idea that discharge serves a basic function in promoting the resolution of grief.

While no research has directly examined the role of emotional discharge, many reports conclude that it is important for the bereaved to be able to talk about the death, their memories, and to express their emotional reactions. As quoted previously, Gorer (1965) concluded that expression of affect was a sign of effective grief work. Parkes (1970) reported that his data supported the conclusions that ". . . grief cannot be permanently postponed and that the longer and more complete the inhibition of feelings the more severe they will be when they finally emerge" (p. 450). The Harvard Project (Glick et al., 1974) noted that the researchers and the widows they studied were aware of the need for discharge:

> The widows also generally recognized that grief needed to be expressed, that too much inhibition of feeling was unnatural and itself could cause difficulties. . . . It may well be that an ability to express grief while yet not permitting it to overwhelm one is an important method of coping. (p. 296)

Maddison and Walker (1967) reported that negative outcome was related to the bereaved feeling that they did not have permission to express affect or to reminisce.

The direct interventions which have been used all included some component to promote discharge. Lindemann (1944) felt that emotional expression was necessary, but viewed it as a painful process. "One of the big obstacles to this work seems to be the fact that many patients try to avoid the intense distress connected with the grief experience and to avoid the expression of emotion necessary for it" (p. 143). Battin et al. (1975) included as the first point of their treatment plan

> Permitting and guiding the patient to put into words and express the affects involved in: the pain, sorrow, and finality of bereavement; a review of the relationship to the deceased; feelings of love, guilt, and hostility toward the deceased. (p. 295)

Volkan's technique of therapy matches Freud's description of the gradual reality confrontation.

> His painful longing must be worked through by surrendering the dead individual piecemeal, as though he were composed of one memory after another, and tension is discharged through weeping. (Volkan et al., 1975, p. 193)

Ramsey's approach of extinction of negative emotional reactions relies directly upon the client being helped to discharge emotions.

> The therapist then allows the reaction, be it a crying fit or an aggressive outburst, to take its course and subside. The therapist then presents that item again, and again, until no further reaction occurs. Then other items are tried out. (Ramsey & Happé, Note 2, p. 9)

Both Silverman (1975) and Twycross (1976) discuss less structured interventions which include providing the bereaved with an accepting listener who gives them a place to talk freely, which is included in Jackins' (1965) list of discharge behaviors.

A survey of the bereaved (Schoenberg, Carr, Peretz, Kutscher & Cherico, 1975) indicated that over 88% of those responding believed expression rather than repression of emotion should be encouraged at least some of the time. They also believed that bereaved individuals should be allowed to discuss distressing memories and talk about their feelings about their loss.

However, not all the literature is this positive about emotional expression. Clayton's group (Bornstein et al., 1973; Clayton et al., 1972; Clayton et al., 1974) does not mention this issue at all, while other descriptive literature (Peretz, 1970) sees no benefit deriving from emotional expression, but only intense suffering and pain.

Rationale and Hypotheses

This project attempts to clarify the role that emotional discharge plays in allowing grief to be resolved. Nichols and Zax (1977) have reviewed the literature relating to the role of catharsis in psychotherapy. In their review of the area of bereavement they conclude that grief is most successfully dealt with by intense, time-limited mourning during which intense weeping occurs. While theoretical and descriptive studies are cited in support of this conclusion, no experimental evidence is noted. In the broader area of the role of emotional discharge in forms of psychotherapy, only one study was found to have quantified catharsis and related it to measures of outcome (Nichols, 1974). It appears that in the realm of grief literature discharge has even less often been an independent variable. Only Maddison and Walker (1967) assessed how the bereaved thought and felt about opportunities for emotional expression, yet even this study contained no direct measures of discharge.

This investigation is based upon the central hypothesis that emotional discharge has a direct and positive effect upon the resolution of grief. A variety of implications arise from the use of Jackins' (1962, 1965) definition of discharge and his model of the natural resolution it produces. First, if a total amount of discharge were quantified, bereaved people who experienced more emotional release would be expected to resolve their grief in a briefer amount of time. In Jackins' terms, they should have less distress remaining about the death and thus should have more ability to function well in daily living

situations. An additional implication is that any form of discharge is equally as beneficial as any other form. Thus the type of discharge should not produce any significant difference in reaching resolution. There should also be no difference between the individual who spends a great deal of time discharging emotion with only one person as compared to the individual who has an equal amount of total discharge experience spread across contacts with several people. The theory would predict that the total amount of emotional discharge should be the discriminating variable in predicting outcome.

The aware attention of another person is described by Jackins (1975) as a prerequisite for discharge. Thus bereaved individuals who cry or shout while alone would not be expected to benefit in the same way as the bereaved who express such reactions to a safe, accepting listener. Emotional behaviors occurring while the bereaved are alone do not function to discharge the distress. The total amount of effective emotional discharge would then include only emotional reactions with other people, while emotional reactions when the bereaved are alone should not contribute significantly to outcome.

Another question is whether prior experiences of discharge would make a significant difference in reaching a resolution. People who have had more experience discharging hurts of any kind may feel more comfortable and have fewer fears of social disapproval, thus leading to a larger amount of discharge during bereavement. However, it may also be that people who have discharged in the past actually have less to discharge during the current grief. Jackins notes that situations often restimulate the experience of prior hurts. A death may then remind a

person of the hurts of other losses which then must also be discharged. Someone who had expressed their emotional reaction at these earlier occasions would have less hurt to be restimulated currently.

It is hypothesized that the total amount of emotional discharge which focuses on the bereavement experience has a significant positive effect on the resolution of grief. Thus the greater the sum of discharge since the death the better the expected outcome of the grief. It is also hypothesized that the type of discharge and the number of individuals involved in this total are not significant. However, it is expected that discharge behaviors require the attention of another person and it is further hypothesized that emotional expressions occurring while the bereaved is alone will make no significant contribution to the prediction of outcome. No specific hypothesis is made regarding the effect of a prior history of emotional discharge.

Methodological Issues

While most longitudinal studies have spanned at least a year using three or four sampling points, this study focuses on the first four months of bereavement and uses weekly data points. This concentrated yet continual data collection appears necessary in order to obtain an accurate record of actual discharge behaviors. When interviews are conducted at an interval of several months, all the information obtained regarding the intervening events is necessarily retrospective and subject to the bias of selective memory processes.

A briefer, four month time span also appears justified by the more narrow focus of this investigation, a question of the efficacy of a

particular behavior in aiding progress toward resolution of grief. The Harvard Study (Glick et al., 1974) suggests that the development of an ongoing method of coping is established rather early in bereavement, and it appears that a discharging style of coping as opposed to an avoidance of reality testing would be defined by the fourth month. Parkes (1970) noted that discharge in the early period of bereavement is not related to heavy discharge in later periods. It may be that immediate discharge permits expression of the immediate hurt, while postponing discharge then requires expression of both the original hurt and restimulated hurts.

Since one form of discharge Jackins (1962, 1965) describes is animated talking, it would seem that extended interviews with the bereaved might contribute to their total discharge experience. Thus a method of data collection may actually become an intervention, promoting discharge and altering the course of grief work. To minimize the intervention aspects of data collection, self-report forms are used to obtain data and interview time is minimized whenever possible. Rather than asking bereaved individuals to retrospectively recall the amount and type of discharge experiences they have had, each individual is asked to keep their own ongoing record of discharge.

Because other independent variables have been related to grief outcome, measures of these dimensions are also included so that they may be controlled. These variables include age, relationship to the deceased, duration of the deceased's illness, duration of the survivor's awareness of terminality (Glick et al., 1974; Parkes, 1975), presence

of other life crises, mode of death, and degree of disturbance or ambivalence which had existed in the relationship (Maddison & Raphael, 1975).

CHAPTER II

METHOD

Subjects

Bereaved individuals were referred to the project by their minister, usually within two weeks of the death. Before referral the minister discussed the project and described the research briefly with each individual. Only those expressing interest to their clergy were referred to the researcher.

Six women and four men ranging in age from 33 to 60 participated in the project. The deaths they had experienced included two people whose mother died, one whose father died, three whose son died (including one husband and wife pair), and four whose husband died.

All but one of the families appeared to be of middle class economic status. One young widow was relying on public assistance funds, and appeared to have been of lower class status before her husband's death. Four subjects were Catholic, three Lutheran, two Presbyterian, and one Baptist.

One other woman, a widow, who was referred by her minister did not participate in the project due to her extreme hearing loss and inability to comprehend the intent of the research.

Due to the small number of referrals received for the longitudinal investigation of grief, further information describing the grief process was obtained by having people still within the first year of

bereavement provide comparative estimates of the extent of their discharge behaviors. Thus a population was sought of individuals bereaved by a close family death within the past year. The criteria for participation were the same as in the longitudinal portion of the study with the exception of the time period since the loss.

Participants in the retrospective portion of the research included seven women and one man, ranging in age from 30 to 65. Two other individuals had indicated an interest in participating, but did not actually do so. Two of the individuals who participated had lost their father, three had lost a son (including one husband and wife pair), and three had lost their husband. The time interval since the death ranged from one year to six months.

Seven of the subjects were respondents to a newspaper article, the eighth was referred by a participant in the longitudinal project. One woman appeared to be of lower socio-economic status, the other individuals appeared to be middle class.

Measures

Discharge Self-Report Forms

Two forms were designed for the bereaved to use each week. One was used to record interpersonal situations where the death was discussed and elicited information about specific discharge behaviors described by Jackins (1962, 1965) and their own personal feelings concerning the conversations. Several responses which are not types of emotional discharge in Jackins' theory were included to provide a broader range of response options.

The other weekly form was designed to obtain information about emotional behaviors which occurred when the bereaved person was alone. The items parallel those of the interpersonal form, except for omitting items appropriate only to an interpersonal context. Two additional items ask questions about health issues. One indicates medical and counseling contacts, the other requests information about the use of prescription medications.

The discharge forms used to collect longitudinal data were revised slightly for use in the retrospective study. The interpersonal discharge forms no longer were used to specify a particular individual, but inquired about interpersonal situations on the average. A separate form was used to inquire about each of four time intervals after the death: the first two weeks, from two weeks to three months, three months to six months, and when appropriate, six months to one year. The forms for discharge which occurred while the individual was alone were also revised to inquire about the four specific time periods of bereavement.

Both types of forms used a seven point rating scale to indicate the amount of discharge or extent of feeling rather than requesting a specific number of occasions the behavior occurred. Both longitudinal and retrospective discharge forms are contained in Appendix A.

Outcome Self-Report Form

The Outcome Self-Report Form is an 18 item multiple choice scale constructed to obtain a combined estimate of both psychological and social adjustment (Appendix B). Most of the items were designed to

match information used to determine outcome in the Harvard Bereavement Study (Glick et al., 1974; Parkes, 1970; Parkes & Brown, 1972). This form was used without revision in the retrospective study.

Life Satisfaction Index

The Havighurst-Neugarten Life Satisfaction Index (Adams, 1969; Neugarten, Havighurst & Tobin, 1961) was revised for use in this study. The scale was originally designed for use with geriatric populations and was normed on a population ranging in age from 50 to 90. The wording of two items was revised to eliminate specific reference to aged populations and the rating scale was increased from a three point to a five point scale for use in both the longitudinal and retrospective studies (Appendix C).

Health Questionnaire

The health questionnaire used by Maddison and Walker (1967) was used as a report of physical symptomatology experienced since the death and health related behavior change (Appendix D). Scoring followed the weighting as communicated by Raphael (Note 3). Responses were given points according to the amount of health deterioration that was indicated when compared to pre-bereavement levels. No revision of this form was necessary for its use in the retrospective study.

Social Readjustment Rating Scale

The Social Readjustment Rating Scale designed by Holmes and Rahe (1967) was revised for use in both the longitudinal and retrospective

studies. This scale was used to obtain an estimate of the degree to which pre-bereavement life crises were present and indicate any concomitant crises occurring during the bereavement. Revision of the scale changed the first time period rated from 0-6 mo. ago to 0-4 mo. ago and added a subjective rating of the adjustment required by the life changes (Appendix E).

Interviewer Rating Form

The Interviewer Rating Form includes the same behaviors as the discharge self-report forms, but was designed to record discharge occurring during research contacts with the interviewer (Appendix F). The interviewer is also asked to estimate the bereaved's current adjustment and their attitude toward their own emotional discharge.

Procedure

Obtaining Referrals

Local ministers were introduced to the research proposal through individual discussions, a presentation to a ministerial study group, and a presentation at a ministerial association meeting. This introduction stressed that anyone referred had the opportunity to refuse an invitation to participate and that this study would not provide any type of counseling or service for the bereaved. Clergy who indicated their interest were sent a detailed letter outlining the procedure for making a referral. All correspondence used to establish a referral system is contained in Appendix G.

All clergy who were not reached by personal meetings were sent a letter informing them that grief research was being organized. Followup

telephone calls were made to answer any questions and explain the study further. Thirty-four of the 62 clergy who were sent letters agreed to participate.

The ministers were asked to use the following introduction when asking bereaved individuals if they wished to participate in the study.

1. A student at the university is trying to find out what happens to people during periods of grief.

2. She would like to find out what things you find helpful or upsetting to you over the next four months.

3. You will be asked to keep a record of your weekly activities. At later times you will be asked to record your impressions of yourself in more general situations and to provide some information about yourself before the death.

4. If you are interested I'll give her your name and she will call you to set up a time to talk with you personally. (Or I'll set up a time to introduce her to you, and then she can talk with you personally.)

Of the 34 clergy who indicated interest in the project, only eight actually made referrals over a seven month period of time. A review of obituary notices indicated that approximately 13% of possible referrals were actually made. This estimate only includes notices where survivors were mentioned and the clergy who had agreed to participate were involved with the funeral. In talking with the clergy, it appears that very few people were asked to participate and declined, but rather that the clergy frequently did not issue the invitation.

In order to obtain referrals for the retrospective study another letter was sent to the 34 clergy who had shown an interest in the

project which requested their assistance. In addition, an article in the local newspaper described the project and encouraged interested individuals to contact the researcher. Only one minister made a referral to this portion of the project, and the individual referred did not participate.

Data Collection

When the bereaved were referred by their minister to the longitudinal study, the interviewer scheduled an initial meeting at their home to begin the study. They were informed that the confidentiality of their data would be maintained, even from their referring minister, and the number labeling of the forms was explained.

During the first meeting the bereaved was given an opportunity to describe the events immediately preceding and following the death. Originally it was expected that this "telling the story" would occur at the end of the meeting, after the project had been explained, and they had agreed to participate. Most of the subjects, however, preferred to talk about the death first, and were reluctant to listen to the explanation of the research until they had done so.

After they had agreed to participate, the subjects were asked to keep a record of the conversations they had about the death or the individual who died and the discharge that occurred by using the interpersonal discharge self-report forms. They were asked to record any discharge that occurred when they were alone by using the second self-report form. Thus, each week the subject would turn in one form for

discharge which occurred while they were alone and one form for each individual with whom they had talked during the week about the death or their grief.

Initially the forms were collected by the interviewer each week, but later were saved and collected after two weeks at the request of the subjects. After each contact with any subject the interviewer completed an interviewer rating form to record any discharge occurring as a direct result of research intervention.

Weekly discharge records were completed for four months after the death. At periods of 1, 2, 3, and 4 months post bereavement (counting from the week of the death) the Life Satisfaction and Outcome Self-Report Forms were given to each subject.

At the end of four months a closing interview was arranged. The Social Readjustment Rating Scale, Health Questionnaire, Life Satisfaction, and Outcome Self-Report Forms were completed. An open-ended tape recorded interview was conducted to complete the necessary identification of the cause of death, awareness of terminality, presence of other life crises, and degree of ambivalence in the previous relationship. Subjects were asked to describe events which had been most or least helpful in dealing with their grief, changes which had occurred in their feelings, and their reactions to the research project.

Three of the widows who were included in the study did not fully participate. They will be identified as Ms. H, Ms. I, and Ms. J. Ms. H and Ms. I did not feel comfortable completing weekly forms, but were willing to participate in initial and closing interviews and completed the final outcome measures. Ms. J was extremely distressed by her grief

and was very anxious to talk about her experience. However, she was unable to focus her attention well enough to understand the use of the data collection measures. Instead, the interviewer talked with her every other week for the four month period of the study, but did not obtain formal data.

Retrospective data were collected in two visits to each individual: one brief explanatory contact and a more lengthy interview. Initially, the project was explained, questions answered, and confidentiality clarified. The subject was then asked to describe their loss briefly to give them an opportunity to talk about the experience. Then the Outcome Self-Report Form, Life Satisfaction Index, Health Questionnaire, and Social Readjustment Rating Scale were left with the subject to be completed on their own. A second visit was then scheduled.

The second session was begun by asking the subject to complete the two types of discharge forms. They were first asked to describe situations while they were alone and then situations with other people which had occurred during the first two weeks of bereavement. Then each consecutive time period was recalled to the best of the individual's ability and the rating of the amount of emotional discharge recorded by them on the forms. Ratings were made in consecutive order to assist the individual's ability to recall as accurately as possible. After all forms were completed a tape recorded open-ended interview was conducted just as had been done in the closing interview with the longitudinal subjects.

Data Scoring and Analysis

Discharge Forms

The interpersonal discharge self-report forms completed each week were used to obtain a weekly total of discharge behaviors which occurred in interpersonal contexts. A summed total number of conversations and total length of time of these conversations was obtained. A weekly sum of each individual discharge behavior was also calculated, indicating the total number of times each subject reported having cried, laughed, or discharged other emotional tension with any other person that week.

As an indication of the total amount of interpersonal emotional discharge reported by any subject, the total number of conversations, total time in conversations, and total times each type of discharge was reported were calculated across the entire four months of the study. Thus "total conversations" refers to the number of conversations reported during the entire four months and "total interpersonal discharge time" refers to the time each subject reported spending in these conversations. As well as a four month total of the occasions each individual discharge behavior occurred, a final total was calculated across the various types, indicating a total sum of all interpersonal discharge during the four months. This sum includes items 4a. through 4k. plus items 4m. and 4n. on the Interpersonal Discharge Self-Report Form (Appendix A).

In a similar way, discharge which occurred while the individual was alone was used to compile a total sum for the entire four months. The time reported in thoughts focused on the loss was totaled to obtain

"total time in discharge alone." Each discharge behavior reported was also summed across the four months yielding a total number of times cried alone, laughed alone, etc. Finally, items 2a. through 2i. were summed to yield a "total discharge alone."

The items on both types of discharge forms which inquired about feelings were used to obtain an estimate of how often individuals experience specific feelings such as fear, hopelessness, relief, etc. The frequency reported for each item was summed to obtain weekly totals; these were then summed across all 16 weeks to obtain a grand total. No sums were made across items as there was no reason to hypothesize feelings such as anger, disbelief, or acceptance as a single entity.

In a procedure paralleling the summation of longitudinal discharge data, the ratings reported by subjects indicating the discharge which occurred both in interpersonal and isolated situations were summed to indicate the relative occurrence of emotional discharge across the entire period of bereavement. Totals were calculated for each individual mode of discharge behavior and across all modes to indicate totals for the entire period of bereavement as well as at the intervals of 2 weeks, 3 months, 6 months, and 1 year.

Totals for the items inquiring about feelings were also computed in a similar manner to that used for the longitudinal data. The ratings by retrospective subjects were summed for each item across the four time periods to obtain a total rating.

Health Measures

The initial 50 items of the Health Questionnaire were given a weighted score, following the procedure used by Maddison and Walker (1967). The final nine multiple choice items were also given weighted scores using the same system, with weights reflecting the amount of post-bereavement change in the behavior. A total score was then obtained by adding across all scored items.

The six items on the Discharge Alone Self-Report Form (Appendix A) which asked about health and counseling issues (items 4 and 5) were used to obtain an indication of concerns across the entire four months. The number of reported occurrences each week was summed for each item to yield a total for the 16 weeks investigated. Whether or not medications were used was scored in a yes/no dichotomy so that the total number of weeks when medication was used could be calculated.

Life Satisfaction Index

Responses to the Life Satisfaction Index were scored one to five, with five being given the direction expressing least current life satisfaction. For each administration of the scale scores could range from a low, or most satisfied, of 18 to a high, or least satisfied, of 90.

For longitudinal subjects Life Satisfaction scores were calculated for each administration of the form, at 1, 2, 3, and 4 months post-bereavement. Retrospective subjects had only one administration of the form, representing their current level of Life Satisfaction.

Outcome Self-Report Form

Responses to the Outcome Self-Report Form were given weighted scoring from one to four. With the exception of items 6, 7, and 8 the weights were subjectively assigned with one representing the most positive outcome and four representing the least positive outcome. For items 6, 7, and 8 the scoring represented a response without any positive or negative interpretation.

Retrospective subjects were given only one administration of the form while longitudinal subjects were given the form at 1, 2, 3, and 4 months post-bereavement. A summed outcome score for each administration was calculated using items 1 to 5 and 9 to 18. This yielded a possible range in scores from 15 for the most positive outcome to 60 for the least positive outcome.

Social Readjustment Rating Scale

This scale was designed to provide an indication of previous life stress and concomitant crises occurring with the bereavement. However, subjects were apparently unable to understand the directions for this form and a majority filled it out incorrectly. The most frequent errors involved leaving sections blank, using check marks instead of number of occurrences, and omitting events which they reported during the extended interviews. Due to the errors, any comparison between subjects in terms of relative life stress would be misleading. Thus the Social Readjustment Rating Scale was not included in data analysis.

CHAPTER III

RESULTS

Discharge Data

Longitudinal Subjects

Examination of each subject's total amount of each type of discharge behavior indicated that several modes of discharge were never reported or occurred so infrequently that they contribute very little to the variance. No subject reported any instance of sobbing, yelling, or pounding in an interpersonal situation, nor any yawning while they were alone. If behaviors reported by no more than two subjects for less than a combined total of ten occurrences are also considered, there was no significant report of yelling, pounding, warm perspiration, cold perspiration, or yawning in either an individual or interpersonal context. Laughing was also reported by only two subjects, but had a higher total occurrence, apparently due to a few specific instances of reminiscing about happy memories. While no sobbing was reported in an interpersonal context, two subjects did report sobbing while alone in eight different weeks for a total of 11 occurrences.

The first column of Table 1 indicates the weekly average occurrence of each recorded behavior by the entire group of longitudinal subjects. Most of the interpersonal discharge which occurred was talking excitedly or relating good or bad memories of the person who died. When individuals were alone remembering good and bad times was not considered

Table 1

Comparative Occurrence of Discharge Behaviors by Context and Subject Group

Discharge Behaviors	Interpersonal				Alone			
	Longitudinal		Retrospective		Longitudinal		Retrospective	
	Mean/wk.	Rank	Total rating	Rank	Mean/wk.	Rank	Total rating	Rank
Talk about/remember good times[a]	18.20	1	115	1	20.06	1	124	1
Talk excitedly[b]	10.67	2	49	10	-	-	-	-
Talk about/remember bad times[a]	9.60	3	62	8	18.13	2	95	3
Ask questions[c]	9.47	4	92	2.5	6.20	6	72	5
Other[c]	5.00	5	66	7	12.33	3	66	6
Seek advice[b,c]	4.20	6	80	4	-	-	-	-
Cry	3.07	7	92	2.5	9.40	5	110	2
Talk reluctantly[b]	2.80	8	33	17	-	-	-	-
Laugh	2.40	9	73	6	.73	8.5	65	7
Trembled	2.27	10	51	9	2.27	7	49	9
Change the subject[b,c]	2.20	11	45	12	-	-	-	-
Try not to think[b,c]	-	-	-	-	14.67	4	60	8
Yawn	.60	12	41	13.5	0.00	14	42	11
Cold perspiration	.33	13	48	11	.07	12.5	43	10
Warm perspiration	.07	14	39	15.5	.60	10	34	14
Sobbed	0.00	16	76	5	.73	8.5	89	4
Yell, shout	0.00	16	39	15.5	.07	12.5	40	12
Pound	0.00	16	41	13.5	.33	11	38	13

[a]These behaviors are not considered emotional discharge for retrospective subjects in Jackins' theory.

[b]This item was not included on both forms.

[c]These behaviors are not considered emotional discharge in Jackins' theory.

an emotional discharge behavior. Thus the most frequent mode of discharge when individuals were alone was crying. However, recalling both positive and negative memories, as well as trying not to think about the death, occurred more frequently when people were alone than any form of actual emotional discharge.

When total interpersonal discharge and total discharge alone are compared, the amount of emotional discharge which subjects reported is seen to vary considerably. Table 2 indicates the weekly total discharge which was reported by each subject in an interpersonal context. Total interpersonal discharge is also indicated as well as the rank order of subjects by this total. Table 3 contains identical information regarding discharge which occurred when subjects were alone. Total occurrences of reported interpersonal discharge range from 8 for Mr. A to 94 for Ms. D. The Spearman rank correlation of the subjects when ordered under both discharge conditions is $r_s = .75$, $p < .05$. If the subjects are dichotomized into high versus low amounts of discharge according to the mean total alone and mean total interpersonal discharge, only Mr. E changes groups, from a low level of discharge when alone, to a high level of discharge in interpersonal situations.

Figures 1 and 2 visually present the weekly discharge totals contained in Tables 2 and 3. Most subjects reported more interpersonal discharge than individual discharge across the entire length of the study. Changing patterns of discharge across time will be discussed in a later section in conjunction with more individual case presentations. The small number of cases involved prevents broad generalization on the basis of small changes.

Table 2

Longitudinal Subjects

Total Weekly Interpersonal Discharge

Week	Mr. A	Ms. B	Mr. C	Ms. D	Mr. E	Ms. F	Mr. G	$\overline{X}$
2	a	a	0	a	a	a	20	2.22
3	a	6	0	34	15	40	2	10.8
4	a	4	50	30	10	22	0	13.0
5	0	0	5	16	9	6	2	4.2
6	0	3	0	26	11	5	1	5.1
7	0	10	0	29	18	7	1	7.2
8	0	0	0	19	17	7	0	4.8
9	0	0	0	21	12	6	0	4.3
10	1	12	0	35	27	7	0	9.1
11	0	0	0	36	16	6	0	6.4
12	0	8	0	21	12	11	1	5.9
13	1	0	0	21	16	5	0	4.8
14	0	0	0	6	7	5	0	2.0
15	1	0	a	11	6	2	2	2.4
16	5	0	2	21	14	5	0	5.2
Total	8	43	57	326	190	143	29	112.42
Rank	7	5	4	1	2	3	6	

[a]No data were collected on this week.

Table 3

Longitudinal Subjects

Total Weekly Discharge When Alone

Week	Mr. A	Ms. B	Mr. C	Ms. D	Mr. E	Ms. F	Mr. G	$\bar{X}$
2	a	a	1	a	a	a	7	4.0
3	a	4	1	16	1	12	0	5.7
4	a	3	0	8	1	9	0	3.5
5	0	2	2	10	0	7	0	3.0
6	0	11	0	14	1	6	0	3.1
7	0	1	0	7	1	0	1	1.4
8	0	2	0	4	1	0	0	1.0
9	0	4	1	5	2	3	0	2.1
10	0	0	0	6	5	1	a	2.0
11	0	0	0	7	2	3	2	2.0
12	0	0	0	1	2	4	1	1.1
13	0	0	0	4	1	3	0	1.1
14	0	0	0	3	1	0	0	.6
15	0	0	a	3	2	2	1	1.3
16	0	0	0	6	2	2	1	1.6
Total	0	27	5	94	22	52	13	
Rank	7	3	6	1	4	2	5	

[a]No data were collected on this week.

Figure 1. Total weekly interpersonal discharge.

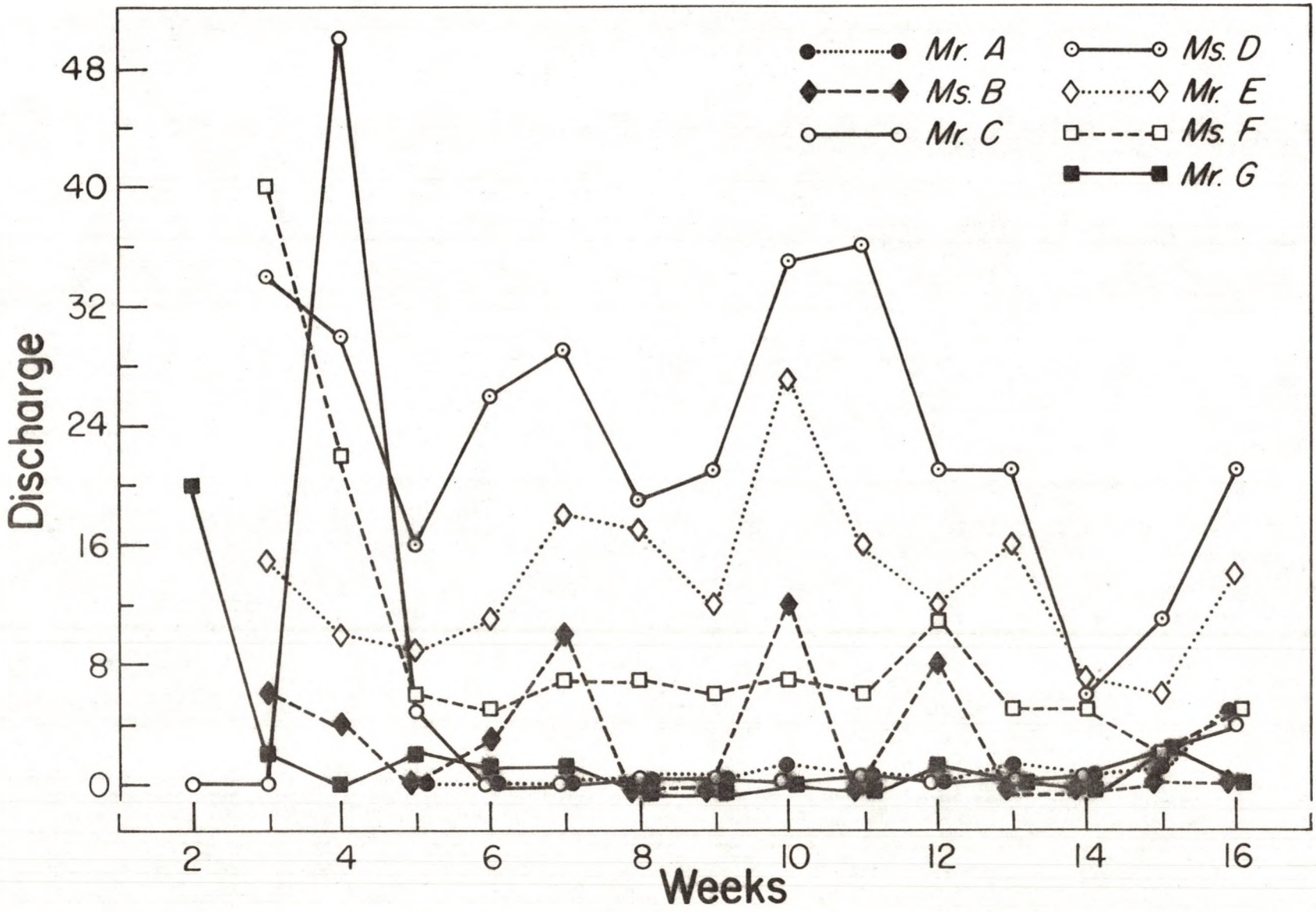
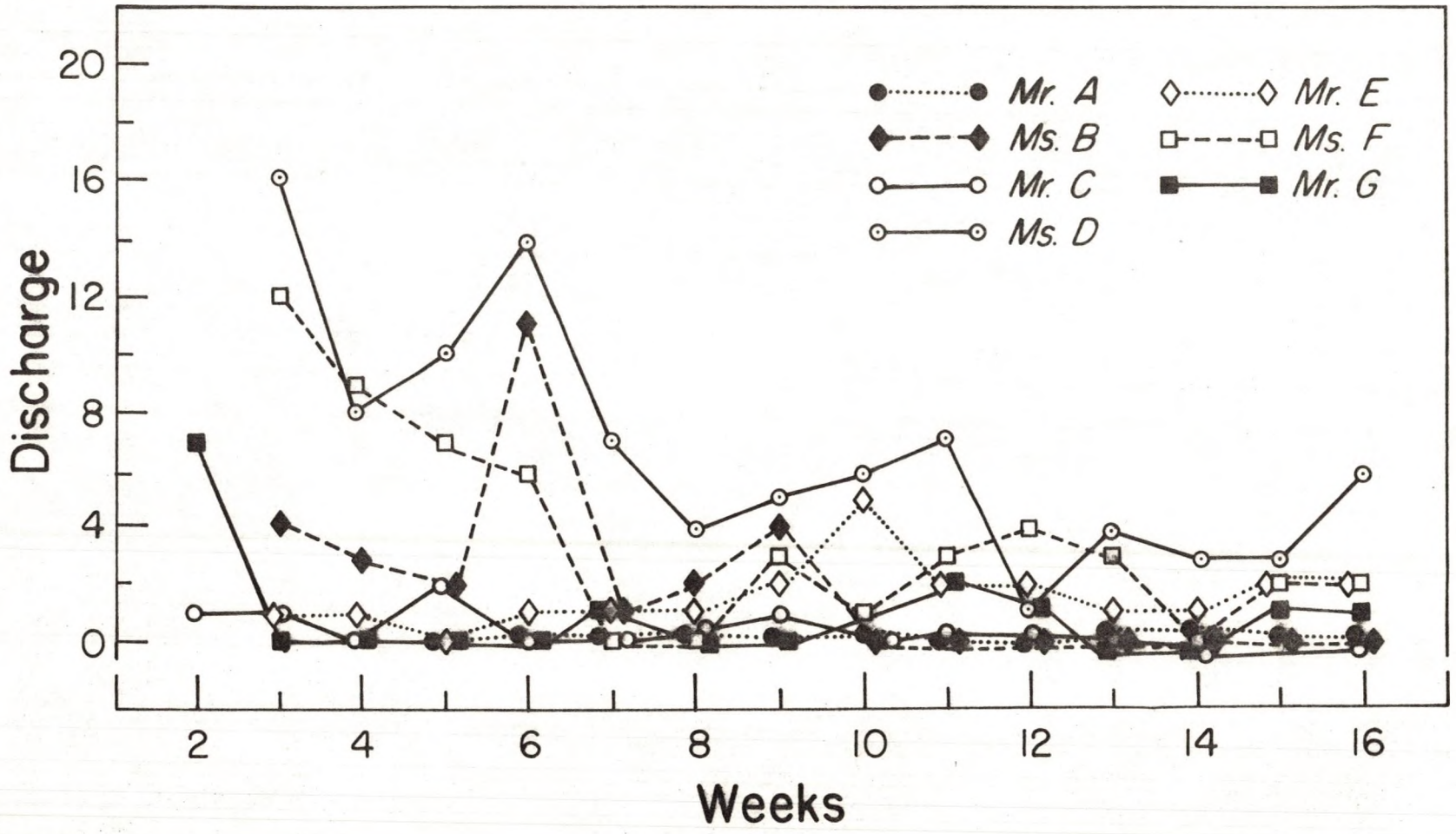

Mr. A
Ms. B
Mr. C
Ms. D
Mr. E
Ms. F
Mr. G
Discharge
48
40
32
24
16
8
0
2
4
6
8
10
12
14
16
Weeks

Figure 2. Total weekly discharge while alone.


Discharge
20
16
12
8
4
0
2
4
6
8
10
12
14
16
Weeks
Mr. A
Ms. B
Mr. C
Ms. D
Mr. E
Ms. F
Mr. G

Average reported ratings of conversations in terms of helpfulness, safety, and understanding were calculated and the subjects rank ordered on each dimension. Spearman rank correlations were then calculated comparing subjects' rating of interpersonal conversations with their total reported interpersonal discharge. Perceived helpfulness of the conversation was significantly correlated with total interpersonal discharge, $r_s = .89$, $p < .01$. However, perceived safety, $r_s = .67$, n.s., and a sense of being understood by the listener, $r_s = .286$, n.s., were not related to the amount of interpersonal discharge.

The total number of conversations and the total reported length of conversations were each used to again rank order subjects for comparison with the total amount of interpersonal discharge recorded. Both number of conversations $r_s = .88$, $p < .05$, and length of conversations, $r_s = .96$, $p < .01$, are directly related to the amount of discharge reported.

Retrospective Subjects

Examination of the summed ratings of discharge behaviors indicated that there were no behaviors which were only rated as "not occurring at all." The summed ratings for all retrospective subjects were combined for each type of behavior and used to rank order the behaviors from most frequent to least frequent, as indicated in Table 1. The weekly average occurrence of these behaviors as reported by the longitudinal subjects were also rank ordered for comparison. In comparing longitudinal and retrospective subjects, the Spearman rank correlation of the frequency of discharge behaviors while alone was $r_s = .78$,

$p < .01$. The rank correlation of the frequency of behaviors in interpersonal situations was $r_s = .57$, $p < .05$.

There is a significant consistency in the relative frequency with which these behaviors are recorded, despite the discrepancies in the time span examined and the need for recall. The retrospective subjects were asked to recall the first two weeks of bereavement, a time span not included for most of the longitudinal subjects. In addition, the total time span examined for recall by the retrospective subjects ranged from six months to one year, rather than only four months.

The most obvious difference in the pattern of reported discharge in interpersonal situations was that the retrospective subjects recalled having cried and sobbed much more frequently relative to other behavior than the longitudinal subjects reported.

It is more difficult to identify high and low discharging subjects in the retrospective group due to the limited variance produced by the use of ratings rather than actual occurrences. Subjects were rank ordered according to their mean rating of discharge behaviors both for discharge reported when alone and for discharge with other people. The correlation between these two sets of ranks was $r_s = .72$, $p < .05$, indicating that individuals who reported high levels of discharge in interpersonal situations also reported high levels when they were alone. Total discharge ratings for each administration of the forms and overall means are shown for each subject in interpersonal situations in Table 4 and in situations when they were alone in Table 5. When subjects are dichotomized at the mean into high versus low amounts of discharge Ms. L, Ms. O, and Ms. Q show consistently high levels of discharge under

Table 4

Retrospective Subjects

Summed Ratings of Interpersonal Discharge

Time period	Ms. K	Ms. L	Mr. M	Ms. N	Ms. O	Ms. P	Ms. Q	Ms. R
Two weeks	28	49	21	24	27	33	24	28
Three weeks	22	27	17	26	29	18	42	23
Six months	24	18	17	20	29	16	40	24
One year	26	13	17	a	22	a	34	21
Total	100	107	72	70	107	67	140	96
$\bar{X}$	25.00	26.75	18.00	23.33	26.75	22.33	35.00	24.00
Rank	4	2.5	8	6	2.5	7	1	5

[a]This time period was not applicable for this subject.

both conditions, while Mr. M, Ms. N, and Ms. R show consistently low levels. Ms. K reports high levels of interpersonal discharge but low levels while alone; Ms. P reports the opposite pattern with more discharge when alone than with other people.

Average ratings of perceived helpfulness, safety, and understanding in conversations with other people were calculated using the four forms inquiring about interpersonal discharge. Rank correlations were then made with reported levels of interpersonal discharge. Unlike the longitudinal subjects, the perceived qualities were all negatively related to level of discharge. Situations in which discharge occurred were not perceived as helpful, $r_s = -.30$, n.s., nor safe, $r_s = -.50$, n.s.

Table 5

Retrospective Subjects

Summed Ratings of Discharge When Alone

Time period	Ms. K	Ms. L	Mr. M	Ms. N	Ms. O	Ms. P	Ms. Q	Ms. R
Two weeks	14	33	13	17	30	34	15	17
Three months	15	20	11	16	31	10	27	15
Six months	14	12	11	14	21	10	29	12
One year	13	10	11	a	19	a	23	16
Total	56	75	46	47	101	54	94	60
$\bar{X}$	14.00	18.75	11.5	15.66	25.25	18.00	23.50	15.00
Rank	7	3	8	5	1	4	2	6

[a]This time period was not applicable for this subject.

Nor were the individuals who listened to this discharge perceived as understanding them, $r_s = -.41$, n.s.

The relationship of number of conversations and length of conversations to total interpersonal discharge ratings could not be evaluated with the type of information obtained from the retrospective subjects.

Outcome Data

Longitudinal Subjects

The ongoing monthly data from the Life Satisfaction Index and Outcome Self-Report Form was available from seven subjects. Two

additional subjects, Ms. H and Ms. I, completed all the outcome measures at a closing interview, providing data from a total of nine subjects at the four month assessment.

Across all administrations, Life Satisfaction scores ranged from 54 to 34. Table 6 presents all the scores on outcome measures for the longitudinal subjects. Most individuals showed only very small changes in Life Satisfaction scores across the four administration of the scale. One way analysis of variance indicated no significant difference between any of the time periods sampled, $F(3, 15) = .27$. Ms. B had the largest change, decreasing her score by nine points from one month post-bereavement to four months post-bereavement. This change indicates an increase in life satisfaction since lower scores are associated with being more satisfied. Two subjects, Mr. E and Ms. F had slight increases in their scores when comparing the one month and four month measures, indicating a decrease in satisfaction. Mr. E indicated even less satisfaction at the three month assessment, the only occasion on which he is above the mean score.

Scores on the Outcome Self-Report form range from 22 to 35 across all administrations of the scale to longitudinal subjects. All subjects except Mr. G showed slight improvement in their adjustment across the four time samples. A one-way analysis of variance indicated that this change across the time intervals was not significant, $F(3, 15) = 1.14$.

Health Questionnaire scores ranged from 0, no health change, to 26. Five of the subjects reported no change while only one, Ms. D, scored more than 16, the range considered poor outcome by Maddison and

Table 6

Outcome Scores for Longitudinal Subjects

Measure	Mr. A	Ms. B	Mr. C	Ms. D	Mr. E	Ms. F	Mr. G	Ms. H	Ms. I	$\bar{X}$
Life Satisfaction										
1 month	a	43	42	43	34	52	49	a	a	43.83
2 months	36	39	40	43	38	51	47	a	a	42.00
3 months	35	38	40	40	45	54	48	a	a	42.57
4 months	35	34	41	43	38	54	48	45	40	42.00
Outcome Self-Report										
1 month	a	31	23	33	28	35	27	a	a	29.50
2 months	26	32	23	35	27	34	29	a	a	29.43
3 months	26	30	23	33	29	34	29	a	a	29.14
4 months	24	29	22	30	27	33	31	29	29	28.22
Health Questionnaire	0	0	0	26	0	7	2	2	0	4.11

[a]No data were collected for this time period.

Walker (1967). Very little information was reported on the six items inquiring weekly about health and counseling issues. Ms. D reported 49 occasions of feeling ill, 3 occasions of seeing her physician, 2 occasions of calling the physician's office, and 10 visits with her clergy. Mr. G indicated the next most frequent reporting, with five occasions of feeling ill.

Table 7 indicates the Spearman rank correlations of the three outcome measures, based upon the Health Questionnaire scores, final Life Satisfaction scores, and final Outcome Self-Report scores. As the correlations indicate, the scores on all three measures are significantly related and present a consistent pattern of good versus poor outcome. Based on these three outcome measures the longitudinal subjects were dichotomized into two groups based upon mean scores, with Mr. A. Ms. B, Mr. C, Mr. E, and Ms. I as good outcome and Ms. D, Ms. F, Mr. G, and Ms. H as poor outcome.

Retrospective Subjects

Table 8 indicates the scores of retrospective subjects on the three outcome measures. Life Satisfaction scores ranged from 79 to 32, with three subjects indicating more dissatisfaction than any of the longitudinal subjects.

Outcome Self-Report scores ranged from 41 to 28, with two subjects again indicating less positive resolution than any longitudinal subject. Health changes reported on the Health Questionnaire were scored from 0 to 27, a range similar to that reported by longitudinal

Table 7

Rank Correlations of Outcome Measures

By Groups

	Longitudinal		
	Health Questionnaire	Life Satisfaction	Outcome Self-report
Health Questionnaire	-	.84**	.81**
Life Satisfaction		-	.68*
Outcome Self-report			-
	Retrospective		
	Health Questionnaire	Life Satisfaction	Outcome Self-report
Health Questionnaire	-	.92**	.75*
Life Satisfaction		-	.90**
Outcome Self-report			-

*$p < .05$.

**$p < .01$.

Table 8

Outcome Scores for Retrospective Subjects

Measure	Ms. K	Ms. L	Mr. M	Ms. N	Ms. O	Ms. P	Ms. Q	Ms. R	$\bar{X}$
Life Satisfaction	37	36	36	65	79	32	55	41	47.62
Outcome Self-report	28	29	29	38	41	28	31	30	31.75
Health Questionnaire	5	3	0	10	27	0	13	3	7.62

subjects. Only Ms. O scored in the range considered poor outcome (Maddison & Walker, 1967), although all but two subjects did report health changes.

The distributions of scores obtained by longitudinal and retrospective subjects on all three outcome measures were compared by the Mann-Whitney U which indicated that there were no significant differences on any measure in terms of the range of scores obtained by each group.

Retrospective subjects also reported more health and counseling contacts on the six items included on the discharge alone forms. All but one subject reported some form of health problem with all but two seeking some professional medical advice. Three subjects had received professional grief counseling and four subjects had been medicated in response to their emotional reaction to the loss.

Spearman rank correlations of the Health Questionnaire, Life Satisfaction, and Outcome Self-Report scores for retrospective subjects are shown in Table 7. Again, the relative orders of the scores obtained on all three of these measures are significantly correlated and permit these measures to be used to divide the subjects into groups of good versus poor outcome. When the mean for the retrospective subjects is used to divide the group, Ms. K, Ms. L, Mr. M, Ms. P, and Ms. R are viewed as good outcome while Ms. N, Ms. O, and Ms. Q are viewed as poor outcome.

Relationship of Discharge to Outcome

The division of subjects into good and poor outcome was compared to the division into high and low discharging subjects by testing the probability of the resulting dichotomized distribution with the Fisher exact probability test. Both longitudinal and retrospective subjects were examined separately according to level of discharge when alone and level of discharge with other people. The probability of obtaining the resulting distributions was at a chance level for all four of the 2 x 2 distributions examined.

For both longitudinal and retrospective subjects, the rank order of scores on each of the three outcome measures was correlated both with the rank order of amount of interpersonal discharge and discharge which occurred when individuals were alone. Table 9 presents these rank correlations. In all instances, for both subject groups, and in both discharge contexts, there is a negative relationship between the amount of discharge reported and positive outcome, although only one of these 12 correlations is significant.

Since relatively low levels of all discharge behaviors were reported in general, and only a very few behaviors were consistently mentioned, no further attempt was made to relate specific modes of discharge to positive or negative outcome.

Further examination of the relationship of outcome to the number of individuals involved in the total number of interpersonal conversations was not attempted. The total number of conversations for longitudinal subjects is directly related to the amount of discharge

Table 9

Rank Correlation of Discharge with Outcome

Outcome measures	Interpersonal discharge	Discharge when alone
	Longitudinal subjects	
Life Satisfaction	-.32	-.36
Outcome Self-Report	-.21	-.68
Health Questionnaire	-.34	-.55
	Retrospective Subjects	
Life Satisfaction	-.46	-.41
Outcome Self-Report	-.36	-.51
Health Questionnaire	-.70*	-.59

*$p < .05$

reported and discharge has been shown to have a nonsignificant negative relationship to outcome measures.

Relationship of Other Variables to Outcome

Feelings During Bereavement

The feelings reported by subjects as having occurred during their bereavement were examined for any relationship which might be associated with outcome. Table 10 indicates the total number of times each specific feeling was reported by each longitudinal subject under both discharge conditions. The subjects are divided into positive and negative outcome groups and mean occurrence of each feeling is given for comparison. Table 11 contains the same information for retrospective subjects with total rating indicated in place of specific occurrences.

Table 10

Total Reported Occurrence of Feelings

By Longitudinal Subjects

Feeling	Positive Outcome					Negative Outcome				Total
	Mr. A	Ms. B	Mr. C	Mr. E	$\bar{X}$	Ms. D	Ms. F	Mr. G	$\bar{X}$	$\bar{X}$
Interpersonal Feelings										
anger				2	.5	3			1.0	.71
hurt				23	5.75	50	3	26	26.33	14.57
embarrassment					0.00		1		.33	.14
relief		3		23	6.50	12	6	16	11.33	8.57
guilt		1	4		1.25	3	2	2	2.33	1.71
boredom					0.00	2			.66	.29
fear				1	.25	5	7	2	4.66	2.14
hopelessness			2	5	1.75	2	1		1.00	1.43
disbelief			3	41	11.00	52	11	4	22.33	15.86
depression		6	2	17	6.25	3	17		6.66	6.43
anxiety		1			.25	9	20		9.66	4.29
acceptance	16	15		67	24.50	133	11	21	55.00	37.57
other		5			1.25				0.00	.71
Feelings When Alone										
anger				5	1.25	3		2	1.66	1.43
hurt			3	27	7.50	41	3	37	20.25	15.86
embarrassment				1	.25				0.00	.14
relief		3		30	8.25	8	2		3.33	6.14
guilt		6	18	2	6.50	2	20	4	8.66	7.43
boredom				1	.25	8			2.66	1.29
fear					0.00	25	20		15.00	6.43
hopelessness				3	.75		3	2	1.66	1.14
disbelief		5	2	40	11.75	56	41	38	45.00	26.00
depression		28	7	16	12.75	1	38		13.00	12.86
anxiety		36		1	9.25		5		1.66	6.00
acceptance	93	106	10	73	70.50	103	5	39	49.00	61.28
other		19	3	22	11.00	89			29.66	19.00

Table 11

Total Reported Occurrence of Feelings

By Retrospective Subjects

Feeling	Positive Outcome						Negative Outcome				Total
	Ms. K	Ms. L	Mr. M	Ms. P	Ms. R	$\bar{X}$	Ms. N	Ms. O	Ms. Q	$\bar{X}$	$\bar{X}$
Interpersonal Feelings											
anger	4	14	4	9	9	8.00	3	4	4	3.66	6.38
hurt	7	16	10	10	20	12.60	3	28	28	19.66	15.25
embarrassment	4	6	4	3	4	4.20	3	4	4	3.66	4.00
relief	16	12	6	3	4	8.20	3	4	4	3.66	6.50
guilt	4	5	6	3	6	4.80	11	4	28	14.33	8.38
boredom	10	4	4	3	4	5.00	3	4	4	3.66	4.50
fear	12	10	4	8	18	10.40	16	28	11	18.33	13.38
hopelessness*	4	10	4	10	8	7.20	13	28	13	18.00	11.25
disbelief	6	10	9	9	17	10.20	13	26	17	18.66	13.38
depression	7	14	9	4	12	9.20	17	17	20	18.00	12.50
anxiety	9	13	6	4	12	8.80	3	28	20	17.00	11.88
acceptance	9	2	11	5	18	9.00	5	6	15	8.66	8.80
other	9		4	3	4	4.00		20	24	14.66	8.00
Feelings When Alone											
anger	4	12	4	11	16	9.40	3	4	4	3.66	7.25
hurt	7	15	9	11	21	12.60	3	28	28	19.66	15.25
embarrassment	4	4	4	3	4	3.80	3	4	4	3.66	3.75
relief	16	8	7	3	4	7.60	3	4	4	3.66	6.12
guilt	4	8	7	3	4	5.20	9	4	28	13.66	8.38
boredom	9	4	4	3	4	4.80	4	4	4	4.00	4.50
fear	15	8	4	9	18	10.80	14	28	11	17.66	13.38
hopelessness	4	9	4	10	12	7.80	11	28	13	17.33	11.12
disbelief	6	8	9	10	14	9.40	11	26	17	18.00	12.50
depression	8	15	9	7	13	10.40	17	17	18	17.33	13.00
anxiety	8	14	4	5	13	8.80	3	28	17	16.00	11.50
acceptance	10		13	4	14	8.20	5	7	19	10.33	9.00
other	4	4	4	3	4	3.80	3	20	22	15.00	8.00

*Fischer test of exact probability indicates $p < .05$.

Subjects were then dichotomized according to the total mean occurrence reported for each feeling (excluding "other") into high versus low groups. Then 2 x 2 distributions were constructed for each feeling reported compared to good or poor outcome for both longitudinal and retrospective subjects. The probability of obtaining these distributions was examined using the Fisher exact probability test. Of the 48 distributions, only one was significant at the .05 level. However, with the large number of comparisons made, one would be expected to be significant on the basis of chance alone.

A test of the distribution of dichotomized scores does not compare the difference in means on the feeling variables for the good versus poor outcome groups. The number of subjects in each group does not support using statistical analysis of the difference between means when magnitude rather than direction of difference is to be tested. Thus a subjective examination was made of the difference in means. It appears that feelings of hurt, fear, and disbelief were more frequent in longitudinal subjects who had more negative outcomes. Retrospective subjects with poorer outcomes reported a higher frequency of most of the more negative feelings including hurt, guilt, fear, hopelessness, disbelief, depression and anxiety. The subjects having a more positive outcome, however, rated themselves as having felt more anger.

Other Predictors of Outcome

As has been previously discussed, a variety of other variables have been found to be related to positive resolution of grief in other studies. Measures of the following variables were also obtained in this

study from both longitudinal and retrospective subjects: age of survivor, sex of survivor, age of deceased, relationship of deceased to survivor, length of survivor's awareness of terminality, length of deceased's illness, number of adults other than the survivor living in the household (over age 18), and number of children living in the household. The original intent of this study was to use cannonical correlations to determine the relationship between measures of outcome and other variables which might be predictors. Unfortunately, the small number of subjects made it impossible to compare such a large number of variables simultaneously.

Instead, a series of multiple regressions were performed, correlating predictor variables with each outcome measure individually; thus there were three multiple regressions for longitudinal subjects and three for retrospective subjects. The results of the multiple regressions must be interpreted with caution due to the fact that some of the assumptions necessary for its use may not have been met. The independent variables included those listed above plus the amount of interpersonal discharge when alone, which were included to assess the comparative predictive power of these variables. Dependent variables were Life Satisfaction scores, Outcome Self-Report scores, and Health Questionnaire scores.

Tables 12 and 13 indicate the results of stepwise forward multiple regression analyses for longitudinal and retrospective subjects respectively. It should be noted that high scores on all outcome measures indicated poorer resolution of grief.

Table 12

Prediction of Longitudinal Outcome Scores

Variable	Multiple R	R Square	Simple R	Overall F	Significance
	Prediction of Health Questionnaire Score				
Discharge Alone	.91	.84	.91	35.44	.001
Number of Children	.92	.85	.04	16.63	.004
Number of Adults	.93	.86	-.14	10.04	.015
Sex of Survivor	.93	.86	-.40	6.23	.052
Length of Illness	.93	.87	-.20	3.90	.146
Age of Deceased	.94	.87	-.49	2.32	.332
Interpersonal Discharge	.94	.89	.83	1.16	.616
	Prediction of Outcome Self-Report				
Relationship of Deceased	.70	.49	.70	6.62	.037
Discharge Alone	.79	.62	.48	4.86	.056
Interpersonal Discharge	.91	.83	.24	8.26	.022
Length of Illness	.95	.90	-.42	9.26	.027
Number of Adults	.96	.93	-.10	8.00	.059
Number of Children	.97	.94	.03	5.49	.162
Age of Deceased	.99	.99	-.51	14.88	.197
	Prediction of Life Satisfaction				
Relationship of Deceased	.65	.43	.65	5.21	.056
Number of Children	.94	.88	.65	21.14	.002
Length of Illness	.95	.90	-.00	14.76	.006
Age of Deceased	.97	.94	-.64	16.81	.009
Awareness of Terminality	.98	.96	-.34	13.18	.030
Sex of Survivor	.98	.97	-.22	9.77	.096
Discharge Alone	.99	.99	.30	42.46	.118

Table 13

Prediction of Retrospective Outcome Scores

Variable	Multiple R	R Square	Simple R	Overall F	Signif-icance
		Prediction of Health Questionnaire Score			
Discharge Alone	.77	.60	.77	9.01	.024
Number of Adults	.90	.80	-.72	10.21	.017
Interpersonal Discharge	.97	.94	.46	21.24	.006
Age of Deceased	.99	.97	-.23	27.56	.011
Awareness of Terminality	.99	.99	-.22	60.82	.016
Age of Survivor	.99	.99	.40	2359.41	.016
		Prediction of Outcome Self-Report Score			
Number of Adults	.59	.35	-.59	3.27	.121
Length of Illness	.90	.82	-.08	11.09	.015
Discharge Alone	.98	.96	.42	29.75	.003
Relationship of Deceased	.99	.98	-.01	30.14	.009
Awareness of Terminality	.99	.99	-.22	67.91	.015
Number of Children	1.00	.99	-.02	20326.12	.005
		Prediction of Life Satisfaction			
Number of Adults	.72	.51	-.72	6.36	.045
Age of Deceased	.88	.78	-.39	9.01	.022
Discharge Alone	.92	.85	.57	7.66	.039
Length of Illness	.98	.95	.14	15.62	.024
Awareness of Terminality	.99	.99	-.29	202.00	.005
Sex of Survivor	1.00	1.00	-.28	260867.39	.001

For both subject groups low levels of discharge when alone and the presence of other adults living in the household were significant predictors of positive outcome on the Health Questionnaire. Prediction of Outcome Self-Report scores was less consistent across subject groups, however, low levels of discharge when alone and a longer period of illness in the deceased were related to positive outcome. For longitudinal subjects the level of interpersonal discharge also contributed significantly to the prediction of outcome. Life Satisfaction scores for both subject groups were related to age of the deceased and the length of illness. High levels of discharge when alone were associated with a more negative outcome for retrospective subjects.

It appears that independent variables other than levels of discharge do contribute significantly to the variance in outcome scores. However, the pattern of these variables is not consistent across different measures of outcome.

Case Description

The following description of individuals who participated in the longitudinal study is grouped according to the relationship between the survivor and the deceased. At times several individuals may be combined to present a more composite description, both in order to point out some generalities and to protect the confidentiality of the subjects. Where necessary, specific details of a situation may be altered to prevent possible identification of the participant.

The Surviving Parent:
Ms. D, Mr. E, Mr. G

Three of the subjects had experienced the death of a son by suicide. In all cases the previous relationship had been highly ambivalent with power struggles regarding discipline and drug use. None of the families, however, reported any previous threat of suicide.

The deaths all occurred in the home and were discovered by family members. For the survivors, an initial period of shock followed, during which they received a great deal of support from friends and family. After the funerals many of the out of town visitors had returned home, but for Ms. D and Mr. E there continued to be frequent calls and visits from friends and clergy.

All three individuals reported high initial levels of emotional discharge both when alone and when with other people. The two men had rapid decreases in the amount of discharge they reported occurring when they were alone, but Mr. E maintained a high level of interpersonal discharge which appeared to occur with his wife. Ms. D had the highest levels of discharge of any participant in the study. She reported that being able to cry and talk about her loss was helpful to her. Ms. D and Mr. E had peaks in the amount of discharge they reported which appeared to correspond with receiving the coroner's report and later selecting a tombstone. (It should be noted that in this northern geographic area, actual burial may take place several months after a death that occurs in the winter.)

All three of these individuals experienced some degree of guilt and used rationalization to deal with it, in one case focusing on their son's relief from suffering, in the other on the fact that the death appeared to be drug influenced. They were all able to return to their regular daily routine shortly after the death, and the interviewer noticed no apparent interference in their ability to do their work.

At the end of the four month collection of data, Ms. D reported feeling somewhat dissatisfied compared to other times in her life, feeling somewhat depressed and lonely. She had also experienced many physical symptoms since the death, such as sleeplessness, nervousness, headaches, and poor appetite. She considered herself to be adjusting well to her loss, but felt she still had more grief to deal with. When Mr. G completed the final outcome measures he described himself as feeling old and tired, with little enthusiasm for activities, but having had few health changes. He avoided talking about his loss with other people, but cried when he was alone.

While Ms. D and Mr. G were in the group of subjects having a more negative outcome, Mr. E was in the more positive outcome group. He still reported feeling some loneliness and depression, but appeared to be looking forward to the future without deep regret about the past. He described himself as having had no health changes at all.

The Widow: Ms. F, Ms. H, Ms. I, Ms. J

Four widows participated in the study, although only one completed all the weekly data forms. Ms. F, the woman who participated fully, was in her mid 30's with several school aged children. Her

husband apparently died of liver disease, although she wasn't certain of his diagnosis. The other widows were all twenty years older, had adult children, and were living alone with their husband at the time of his death. These three men all died of sudden heart attack or stroke.

Ms. F described having known her husband was critically ill approximately one week before his death. She appeared to have a small support system consisting of her family and her clergy who were very supportive during the first weeks and remained available to her. She reported relatively higher levels of emotional discharge in comparison to other subjects, which showed a rather consistent decline across time. This woman appeared to have the most disrupted life style; she was concerned about child care, had to change her work situation, and eventually moved. At the closing interview she was quite dissatisfied, and indicated the poorest adjustment of any longitudinal subject on the Life Satisfaction and Outcome Self-Report measures. However, in talking with the interviewer she was able to acknowledge tension in her marriage, discuss frustration she felt in her husband's reluctance to seek medical attention, and mention plans she was considering to return to school to learn new job skills.

While Ms. H and Ms. I experienced similar circumstances, their responses reveal some interesting contrasts. During her initial interview Ms. H stated that she did not expect to experience severe grief since her husband had traveled away from home. She did not want to complete the weekly forms because they reminded her that the death had occurred. Four months later Ms. H volunteered that her grief had been much more difficult than she had anticipated, describing a somewhat

delayed onset when she finally realized her husband was not "just on another trip." She was startled to be asked about emotional discharge, indicating that such behavior must be kept very private or "other people won't want to be with you anymore." She appeared to have relationships with several close friends, but referred to tensions with her husband's family. She was not employed, and occupied herself with sewing projects and yardwork. Ms. I had declined to complete weekly forms due to her belief that the best way for her to deal with her grief was to focus on living an active life without reminding herself of her loss. She reported having a great deal of support from friends and church contacts. Her emotional discharge often took the form of reminiscing with friends, and for several months another woman whose husband was hospitalized lived at her house. She had worked part-time previous to her husband's death and had increased this time. She described close relationships with her adult children and planned to continue using their vacation home.

Ms. J appeared to be the most distressed of all the longitudinal subjects. She was never able to attend to an explanation of data collection, but would immediately relate to the interviewer her recent thoughts about her husband. During later periods of the study, she stated that no one else she knew would listen to these thoughts.

Ms. J described a great deal of guilt for having taken her husband for granted. She had extremely ambivalent feelings toward all her adult children involving disappointment in their life styles and feeling emotionally distanced from them, which had existed prior to her husband's death. She did not discuss her loss with family or friends, but

would instead mention her grief to strangers such as store clerks. Having a strong fundamental religious belief, she often attempted to interpret events preceding and following the death in religious terms. Her church, however, provided little actual human support, and her minister made no followup visits after the funeral.

Ms. J poignantly described the symptoms which Parkes (1972) has labeled searching behaviors. She regularly anticipated his greeting at the door, expected him to be in his chair, and even tried to call him on the telephone when she was away from home. She constantly had to force herself to believe he was dead and only was able to dispose of his personal belongings by telling herself that they could be replaced if he came back. She attempted to give reason and meaning to his death by viewing it as having special purpose in God's plan.

During the first three months of her bereavement, she had a young school-aged relative staying with her so that she would not be alone at night. By the end of four months, she was able to stay alone, and could more easily accept the interviewer's departure. However, she continued to appear quite distressed, focusing her daily activity on doing things "as he would want me to."

The Surviving Child:
Mr. A, Ms. B, Mr. C

Three longitudinal subjects experienced the death of a parent. They were between the ages of 30 and 60, and their parents were aged 60, 85, and 91. These individuals appeared to be the least distressed by their grief, reported little emotional discharge, and had the most positive resolution of grief as assessed by the three outcome measures.

Mr. A reported experiencing little grief over the death of his father. The entire family had several months anticipation of the death, and his father had requested that his cancer not be treated. Communication was very open in this family; grandchildren made tape-recorded autobiographical interviews with him at his bedside.

The death of Ms. B's mother from a heart attack was unexpected, but in looking back Ms. B noted that her mother had been recently hospitalized and her father had died previously. Her emotional discharge appeared to center on reminiscing with her siblings in cleaning her mother's house.

Mr. C had brief warning of his mother's death. He was tearful at the immediate time and felt some guilt at not having spent more time with her. These feelings were soon followed by a sense of relief that she would no longer experience a painful illness.

All three of these subjects felt support from their family, friends, and church. They had less daily adjustment to make, since none had been living in the same household with their parent. While they appeared to feel less intense emotional response, they all also described themselves as having been raised in an atmosphere of emotional restraint.

Retrospective Subjects

The data collection method in the retrospective portion of the study provided less opportunity for learning the details of each individual's grief. The circumstances of the individuals having positive resolution appear to differ little from that of the longitudinal

subjects, thus only the retrospective subjects with more negative outcomes will be discussed individually.

Ms. N, in her 30's, experienced the sudden death of her father from a heart attack. At the time she was separated from her husband and had several preschool children. A major factor in her poor resolution of her grief appeared to be the lack of a support system. She described feeling totally alone after the official mourning at the funeral and found no one who would listen to her thoughts. She reported low levels of emotional discharge and at six months post-bereavement she indicated dissatisfaction, moderate amounts of health change, and described herself as doing less well than she had anticipated. It is also likely that she may have had more attachment to her father than most adult daughters, as reflected in her statement ". . . how does one stop thinking when you love someone as much as I loved, and will always love, my Dad." At the time of data collection she had begun to see a professional counselor to deal with her grief.

Ms. O described herself as the most distressed individual in the entire research project. She reported continual loneliness, with feelings of fear, panic, nervousness, and shortness of breath. Ms. O had never accepted the terminality of her husband's cancer until the day he died. Shortly after the death she moved and began work, but found herself unable to concentrate and quit. Throughout her bereavement she used tranquilizers and antidepressants, and shortly before the anniversary of the death she began counseling. Although she reported high levels of discharge behaviors, she described feeling uncomfortable talking with friends about the loss and felt that family and clergy did not

understand her needs. She found new acquaintances at her job the easiest to talk with; she felt less of an imposition telling them "her story" since they had not already heard it. During the first several months of bereavement she frequently talked to her deceased husband and later wrote letters to him, finding both behaviors to be helpful. Currently, she is able to talk with one adult son and another widow she has met. At the time of data collection, she had returned to work.

Ms. Q reported strong guilt feelings in response to her husband's unexpected death. He had apparently been sick for several years, but his problem had never been diagnosed correctly; she, in turn, was frequently frustrated and angry. Ms. Q had high ratings of discharge behaviors, particularly when she was alone. After a year of bereavement she continued to have memory loss, dizziness and a sense of confusion. She felt very angry and resentful in response to the role she felt widows were given in society as a whole. Paralleling the responses of Ms. N and Ms. O, she also felt deserted and isolated by former friends and eventually sought professional counseling.

When the personal comments of all the subjects are considered, it appears that few of them thought of their grief reaction in terms of emotional discharge. Most of them, however, did mention how important it was to them to feel that they had someone to talk with about the death. Individuals who experienced difficulty in the retrospective group and were identified as having a negative resolution all mentioned not having had someone with whom they felt comfortable talking about their feelings. According to their description the sense of being alone could result from actually not having contact with other adults or in

being disappointed by the reaction of others. It appeared that the bereaved felt a lack of support when they perceived that friends and family were tired of hearing about the loss and did not want to listen to their expression of loss.

CHAPTER IV

DISCUSSION

Hypotheses

The central hypothesis that level of emotional discharge is positively related to the resolution of grief was not supported by the rank correlation of subjects' reported levels of emotional discharge behavior and three measures of outcome. Assessments of life satisfaction, psycho-social adjustment, and physical health all had negative rank correlations with level of interpersonal discharge and discharge when the individual was alone. Further multiple regression analyses indicated that the amount of discharge which occurred when subjects were alone contributed more variance to poor outcome on all three measures than the level of interpersonal discharge. When individual case reports are taken into consideration, however, the relationship between emotional discharge and resolution of grief is less clear.

A majority of subjects, especially those who reported high levels of discharge, subjectively reported that talking about their loss and expressing their grief to other people was helpful and made them feel better. Longitudinal subjects who reported heavy interpersonal discharge rated these conversations as helpful but not necessarily a situation in which they felt safe or understood.

The additional hypothesis was made that emotional discharge which occurred without the attention of another person would not make a significant contribution to the prediction of outcome. The data,

instead, indicated that this form of discharge was a significant predictor of outcome, but of negative rather than positive outcome. Thus, discharge which occurs in isolation may actually be detrimental, rather than a neutral event.

A central issue in interpretation of results is whether individuals in the longitudinal group who were labeled as having a negative outcome are actually comparable to those of the retrospective group who had a negative outcome. The retrospective subjects indicated more distress on all outcome measures than the longitudinal subjects when the mean scores are examined. In addition, when the scores of each individual labeled as having negative outcome are compared, again the retrospective subjects indicate less satisfaction, less psycho-social adjustment, and more health changes. The subjective impression of the interviewer was that of the longitudinal subjects, only Ms. J, for whom no outcome measures were available, displayed as much life disorganization as Ms. N, Ms. O, and Ms. Q had described.

These four individuals displayed several of the symptoms Lindemann (1944) used to identify morbid grief. Change in relationships with friends and family, hostility toward specific people, loss of patterns of social interaction and agitated depression were all reported. Changes reported by Marris (1958) were also present in the physical symptoms and social withdrawal which were described.

The contribution of the two forms of discharge behavior to the variance in outcome is confused by several other aspects of the study. The variety of loss involved in the subjects' bereavement indicates a very heterogeneous population. The death of children and spouses

produces much more pain than that of parents (Gorer, 1965). With one exception, Ms. N, the individuals having poorer outcome had experienced more difficult grief. The heaviest two dischargers in each subject group had experienced the loss of a child or spouse, which would be expected to produce more intense grief. If emotional discharge were an important means of resolving grief, these individuals might need to have more emotional discharge, and might need to continue these behaviors over a longer period of time than individuals who were bereaved by a parent's death. The age of the widows participating in the study varied more than in previous research which has examined widows (Glick et al., 1974). Previous research has indicated that as a group younger widows experience more severe grief than older widows (Parkes, 1964a). Thus at a four month assessment of the degree of resolution, different initial levels of distress were not considered; individuals who appeared to have relatively poorer resolution when compared to others with different types of bereavement might appear to have had a more positive resolution if compared with only those experiencing the same type of loss. The longer time interval from the death included in the retrospective study may permit a more accurate assessment of resolution. All the individuals identified as having negative resolution in the retrospective study had experienced obvious disruption of their daily activity and had required professional therapy. It is significant that all three individuals identified a lack of opportunity to share their grief with other people as a major focus of their problems.

Maddison and Raphael (1975) reported that individuals having poor resolution as measured by the Health Questionnaire had indicated a

greater need for an opportunity to express their feelings and a higher frequency of non-helpful interactions than bereaved individuals with positive outcomes. If Ms. J, Ms. N, Ms. O and Ms. Q are considered the poor resolution group in the present study, their self-report closely parallels the description of Maddison and Raphael's poor outcome group. There may be individual differences in the need to communicate feelings or specific situational variables which make communication more important. The Harvard Bereavement Study (Parkes, 1975) concluded that the length of time the bereaved had anticipated the death was a significant predictor of outcome. In the present study the length of awareness of terminality was difficult to determine since in recalling the days preceding a death the subjects often mentioned signs of impending death which they had not recognized at the time. However, of the four subjects being considered here, all had less than three days anticipation of the death.

The reporting of the amount of discharge behaviors may have been systematically altered for the longitudinal subjects by the forms which were used. Each week individuals were given one form on which to record all the discharge which occurred any time that week while they were alone. On the other hand they were instructed to use a separate form for each individual with whom any discharge occurred during the week. Thus in terms of the quality of forms, a ten minute conversation required as much paper as hours of time spent alone. All subjects reported more interpersonal discharge behavior than discharge behavior in isolation. This may have been due to a response bias established by

the use of the single form for the "alone" context, making it more easy to overlook recording of many occasions of discharge.

The hypothesis that conversations with a few individuals would be as helpful as the same number of conversations or amount of time spent with many different people was not tested directly. There was anecdotal suggestion that having even one person to talk to about the grief was helpful and viewed as an important factor in resolution.

As a whole, subjects reported much less emotional discharge, both when alone and when with other people, than had been anticipated. Subjects tended to report the less dramatic forms of discharge, and most reported talking or thinking about the person who died as their primary grief behavior. No direct test was made to see if specific forms of discharge were more related to positive outcome due to the low frequencies reported. During their closing interview some subjects appeared to describe having done more emotional discharging than they reported. This may have been due to subjects having difficulty recognizing discharge at the time it occurred or due to embarrassment in specifically recording such behaviors. Subjects were provided no specific definition of the discharge behaviors listed in the data collection forms and thus provided their own subjective definition of the type and amount of a behavior necessary in order for it to be recorded. It may be that structured weekly interviews, while providing discharge opportunities in themselves, would allow more consistency in describing weekly activities.

The small number of subjects prohibits any firm conclusions concerning sex differences. However, of the male subjects only Mr. E had a level of discharge above the mean, and only when he was alone. It is

likely that socialized norms of what behaviors are appropriate does effect the emotion which men feel comfortable expressing.

Methodological Issues

This project made clear that it is not appropriate to compare individuals with different types of loss. Future investigations should focus on the grief resulting from the loss of a single type of relationship or include enough subjects from each type of relationship to justify analysis of data by groups.

The recruitment method proved to be insufficient to provide enough participants for making broader generalizations from the data. While many clergy expressed an interest in co-operating with the project, they frequently reported that an individual was too upset or inappropriate to approach with an invitation to participate. It appeared that they had emotional reactions to having to approach a very distressed individual and thus did not extend invitations to all their bereaved parishioners. The referral system then introduced an uncontrolled selection factor. While a more direct invitation to the bereaved based on obituary notices or death certificates might be more intrusive, there would surely be a more consistent form of contact and approach.

Several of the longitudinal subjects indicated that the time frame of the project had missed their most intense period of emotional expression. Most subjects began participating in the study between two and three weeks after the death. Frequently they reported that they had already noticed a decrease in their grief behavior saying, "You should have asked me this two weeks ago." Ideally, research in the area of

bereavement should either begin at the time of death, or at least inquire systematically about the events between the death and the beginning of ongoing data collection.

One issue raised by the inclusion of the retrospective portion of the study was whether retrospective data would be as useful as longitudinal data, making intrusive ongoing data collection unnecessary. It appeared that evaluating resolution at a further distance from the death, at six months to one year, provided an accurate assessment of positive versus negative outcome. However this data was based on current feelings of the retrospective group, not upon recall of earlier points in time. Their ratings of the amount of discharge which they had done could not be validated. It would have been helpful, however, if the longitudinal subjects could have had followup assessments on the three outcome measures at six months and one year post-bereavement in order to more clearly define their degree of resolution.

Measures

Issues concerning the discharge forms have been mentioned previously. For longitudinal subjects the use of the forms may have provided different response demands, while for both subject groups there was no estimate of the reliability with which discharge behaviors were reported either within or between subjects. The relative amounts of discharge reported had some face validity in that no subject described themselves during the interview as having behaved significantly differently than their recorded report.

While no reliability co-efficients were calculated, the scores obtained on the Life Satisfaction and Outcome Self-Report Forms were highly consistent within subjects. In addition, no significant difference was found between the distributions of longitudinal and retrospective scores on these measures.

Reliability estimates could not be made for the Health Questionnaire, however, the Maddison and Walker (1967) criterion for poor outcome appeared valid. All three outcome measures did appear to have concurrent validity based on their high rank correlations with each other. If the need to have sought professional counseling is used as a criterion measure, the three outcome measures were highly valid in their ability to predict a poor resolution of grief in the retrospective subjects.

The Health Questionnaire may be a more powerful measure when used further from the time of the death. Physical symptoms take time to develop, and as Jacobs and Ostfeld (1977) indicated, the greatest physical risk appears to lie between six months and two years post-bereavement.

Conclusions

Using three measures of outcome, this study identified groups of individuals who had a relatively positive or negative resolution of grief. The data indicated that positive resolution was related to low levels of emotional discharge behavior when individuals were alone, and to other variables including the presence of other adults in the household, the deceased having been ill for a period of time, and the deceased being

older. Subjective reports from the participants also indicated that bereaved individuals felt it was very important and helpful for them to have someone to talk to about their loss.

As shown by the retrospective subjects, some individuals who have severe grief reactions seek professional help before the first anniversary of the death. If there is any preventive step to be taken in helping people to avoid severe grief reactions, it needs to occur early in bereavement.

In considering any intervention there needs to be a decision as to who will be the target population. Most bereaved individuals can handle their grief well in the context of their social support system. This study indicates that those at risk are individuals who feel they have no one to talk to. For these individuals the death is likely to have been sudden, the deceased younger rather than older, and the survivor living alone or with no other adult. If the age of the deceased is ignored, the description seems to indicate that widows and widowers are in particular risk.

One factor in this description of the poor griever which is not clear, is whether there are actually no available listeners in the environment, or whether the griever is unable to perceive that there are individuals available to give them attention. Several of the bereaved mentioned that after their own loss they wished they had been more available to others they had known who had been bereaved. They noted that what people actually said was usually less important than the fact that they had made an effort to keep in touch with them. The behavior of the clergy, their frequent lack of ongoing contact with recently

bereaved individuals, would suggest that sometimes there is an actual withdrawal of some of the environmental support systems.

Two possible approaches toward prevention of severe grief reactions are apparent. One approach would involve a general educational effort to inform the public of how helpful their contacts can be with the recently bereaved. Many people apparently feel the need to have some special skill or knowledge to help grieving friends; they can be reassured that their concern and willingness to listen are helpful steps in their own right. A second approach would involve taking steps after a grief occurs. Any bereaved person who lives alone, but especially widows and widowers, could benefit from an opportunity to talk about their loss and reminisce. Organized groups such as church congregations could insure that the bereaved had ample opportunity to have someone listen to their feelings.

APPENDIX A

DISCHARGE FORMS

WEEK OF_____ TO _____ NUMBER_____

Use one page for each person you talked to about the death this week.

1. Person_____ Their relationship to you_____

2. Indicate the number of times you talked with them about the death this week: 1 2 3 4 5 6 7 8 9 10 More_____

3. Approximately how much total time did these conversations take?_____

4. Indicate how many times you did each of the following during the times you talked about the death with this person. (1,2,3,4,5,6,7, 8,9,10 or more)

__a. cried
__b. sobbed
__c. trembled/shook/shivered
__d. had warm perspiration
__e. had cold perspiration
__f. talked reluctantly
__g. talked excitedly
__h. laughed
__i. yelled/shouted
__j. pounded fist/gestured angrily
__k. yawned/stretched
__l. changed the subject
__m. described good times
__n. described bad times
__o. asked questions
__p. sought advice
__q. other_____

5. During the conversations how many times did you feel each of the f ollowing in relation to the person who died?

__a. anger
__b. hurt
__c. embarrassment
__d. relief
__e. guilt
__f. boredom
__g. fear/scared
__h. hopelessness
__i. disbelief
__j. depression
__k. anxiety
__l. acceptance
__m. other_____

6. How helpful were these conversations for you?

made things much worse	made things a little worse	didn't change anything	helped a little	helped a lot
_____	_____	_____	_____	_____

7. How safe did you feel to say anything you wanted?

felt very unsafe	felt a little unsafe	felt OK	felt somewhat safe	felt totally safe
_____	_____	_____	_____	_____

8. How well did the person seem to understand what you were thinking and feeling?

understood exactly	understood very well	understood pretty well	didn't understand too well	misunderstood
_____	_____	_____	_____	_____

WEEK OF_____TO_____ NUMBER_____

Describe the times when you were alone this week and thought about your loss.

1. Approximately how much total time did these thoughts occupy each day? _____

2. Indicate how many times you did each of the following during times you were alone this week and thought about your loss. (1,2,3,4,5,6, 7,8,9,10 or more)

__a. cried
__b. sobbed
__c. trembled/shook/shivered
__d. had warm perspiration
__e. had cold perspiration
__f. laughed
__g. yelled/shouted
__h. pounded fist/gestured angrily
__i. Yawned/stretched
__j. tried not to think about it
__k. remembered good times
__l. remembered bad times
__m. asked questions
__n. other_____

3. How many times did you feel each of the following in relation to the person who died when you were alone?

__a. anger
__b. hurt
__c. embarrassment
__d. relief
__e. guilt
__f. boredom
__g. fear/scared
__h. hopelessness
__i. disbelief
__j. depression
__k. anxiety
__l. acceptance
__m. other_____

4. How many times this week did you:

__a. Visit your physician's office
__b. Call your physician's office
__c. Receive other medical service (explain)
__d. Feel physically ill, but seek no professional treatment
__e. Visit your minister
__f. Visit a counselor

5. Did you take any prescription medication this week? Yes__ No__

If you know them, please list the name and dosage of your medications. If not known, please describe as well as you can.

Name of medication	Amount of single dosage	Frequency of dosage

NUMBER_____

Describe the times during the first two weeks when you talked with other people about your loss.

1. Approximately how many people did you talk to each day?_____

2. Approximately how much total time did these conversations occupy each day?_____

3. Indicate how much you did each of the following during the times you talked with other people about your loss. Use a number from 1 to 7, where 1 represents not doing it at all and 7 represents doing it a great deal.

__a. cried
__b. sobbed
__c. trembled/shook/shivered
__d. had warm perspiration
__e. had cold perspiration
__f. talked reluctantly
__g. talked excitedly
__h. laughed
__i. yelled/shouted
__j. pounded fist/gestured angrily
__k. yawned/stretched
__l. changed the subject
__m. described good times
__n. described bad times
__o. asked questions
__p. sought advice
__q. other_____

4. During the conversations how much did you feel each of the following in relation to the person who died? Again, use a number from 1 to 7, where 1 represents not feeling it at all and 7 represents feeling it a great deal.

__a. anger
__b. hurt
__c. embarrassment
__d. relief
__e. guilt
__f. boredom
__g. fear/scared
__h. hopelessness
__i. disbelief
__j. depression
__k. anxiety
__l. acceptance
__m. other_____

5. How helpful were these conversations for you?

made things much worse	made things a little worse	didn't change anything	helped a little	helped a lot
_____	_____	_____	_____	_____

6. How safe did you feel to say anything you wanted?

felt very unsafe	felt a little unsafe	felt OK	felt somewhat safe	felt totally safe
_____	_____	____	____	_____

7. How well did the other people seem to understand what you were thinking and feeling?

understood exactly	understood very well	understood pretty well	didn't understand too well	misunderstood
_____	_____	_____	_____	_____

8. Who did you talk with most frequently and how many times did you talk with them?

1. 3.

2. 4.

NUMBER_____

Describe the times from two weeks to three months after the death when you talked with other people about your loss.

1. On the average, how many people did you talk with about your loss:
   __more than once a day
   __once a day
   __once a week
   __once a month
   __less than once a month

2. On the average, how much time did each of these conversations occupy? _____

3. Indicate how much you did each of the following during the times you talked about your loss. Use a number from 1 to 7, where 1 represents not doing it at all and 7 represents doing it a great deal.

__a. cried
__b. sobbed
__c. trembled/shook/shivered
__d. had warm perspiration
__e. had cold perspiration
__f. talked reluctantly
__g. talked excitedly
__h. laughed
__i. yelled/shouted
__j. pounded fist/gestured angrily
__k. yawned/stretched
__l. changed the subject
__m. described good times
__n. described bad times
__o. asked questions
__p. sought advice
__q. other _____

4. During the conversations how much did you feel each of the following in relation to the person who died? Again, use a number from 1 to 7, where 1 represents not feeling it at all and 7 represents feeling it a great deal.

__a. anger
__b. hurt
__c. embarrassment
__d. relief
__e. guilt
__f. boredom
__g. fear/scared
__h. hopelessness
__i. disbelief
__j. depression
__k. anxiety
__l. acceptance
__m. other_____

5. How helpful were these conversations for you?

made things much worse	made things a little worse	didn't change anything	helped a little	helped a lot
_____	_____	_____	_____	_____

6. How safe did you feel to say anything you wanted?

felt very unsafe	felt a little unsafe	felt OK	felt somewhat safe	felt totally safe
_____	_____	_____	_____	_____

7. How well did the other people seem to understand what you were thinking and feeling?

understood exactly	understood very well	understood pretty well	didn't understand too well	misunderstood
_____	_____	_____	_____	_____

NUMBER_____

Describe the times from three months to six months after the death when you talked with other people about your loss.

1. On the average, how many people did you talk with about your loss:
   __more than once a day
   __once a day
   __once a week
   __once a month
   __less than once a month

2. On the average, how much time did each of these conversations occupy? _____

3. Indicate how much you did each of the following during the times you talked about your loss. Use a number from 1 to 7, where 1 represents not doing it at all and 7 represents doing it a great deal.

__a. cried
__b. sobbed
__c. trembled/shook/shivered
__d. had warm perspiration
__e. had cold perspiration
__f. talked reluctantly
__g. talked excitedly
__h. laughed
__i. yelled/shouted
__j. pounded fist/gestured angrily
__k. yawned/stretched
__l. changed the subject
__m. described good times
__n. described bad times
__o. asked questions
__p. sought advice
__q. other _____

4. During the conversations how much did you feel each of the following in relation to the person who died? Again, use a number from 1 to 7, where 1 represents not feeling it at all and 7 represents feeling it a great deal.

__a. anger
__b. hurt
__c. embarrassment
__d. relief
__e. guilt
__f. boredom
__g. fear/scared
__h. hopelessness
__i. disbelief
__j. depression
__k. anxiety
__l. acceptance
__m. other _____

5. How helpful were these conversations for you?

made things much worse	made things a little worse	didn't change anything	helped a little	helped a lot
_____	_____	_____	_____	_____

6. How safe did you feel to say anything you wanted?

felt very unsafe	felt a little unsafe	felt OK	felt somewhat safe	felt totally safe
_____	_____	____	_____	_____

7. How well did the other people seem to understand what you were thinking and feeling?

understood exactly	understood very well	understood pretty well	didn't understand too well	misunderstood
_____	_____	_____	_____	_____

NUMBER_____

Describe the times from six months to one year after the death when you talked with other people about your loss.

1. On the average, how many people did you talk with about your loss:
   __more than once a day
   __once a day
   __once a week
   __once a month
   __less than once a month

2. On the average, how much time did each of these conversations occupy? _____

3. Indicate how much you did each of the following during the times you talked about your loss. Use a number from 1 to 7, where 1 represents not doing it at all and 7 represents doing it a great deal.

__a. cried
__b. sobbed
__c. trembled/shook/shivered
__d. had warm perspiration
__e. had cold perspiration
__f. talked reluctantly
__g. talked excitedly
__h. laughed
__i. yelled/shouted
__j. pounded fist/gestured angrily
__k. yawned/stretched
__l. changed the subject
__m. described good times
__n. described bad times
__o. asked questions
__p. sought advice
__q. other _____

4. During the conversations how much did you feel each of the following in relation to the person who died? Again, use a number from 1 to 7, where 1 represents not feeling it at all and 7 represents feeling it a great deal.

__a. anger
__b. hurt
__c. embarrassment
__d. relief
__e. guilt
__f. boredom
__g. fear/scared
__h. hopelessness
__i. disbelief
__j. depression
__k. anxiety
__l. acceptance
__m. other _____

5. How helpful were these conversations for you?

made things much worse	made things a little worse	didn't change anything	helped a little	helped a lot
_____	_____	_____	_____	_____

6. How safe did you feel to say anything you wanted?

felt very unsafe	felt a little unsafe	felt OK	felt somewhat safe	felt totally safe
_____	_____	____	_____	_____

7. How well did the other people seem to understand what you were thinking and feeling?

understood exactly	understood very well	understood pretty well	didn't understand too well	misunderstood
_____	_____	_____	_____	_____

NUMBER_____

Describe the times when you were alone during the first two weeks and thought about your loss.

1. Approximately how much total time did these thoughts occupy each day? _____

2. Indicate how much you did each of the following during times you were alone and thought about your loss. Use a number from 1 to 7, where 1 represents not doing it at all and 7 represents doing it a great deal.

__a. cried
__b. sobbed
__c. trembled/shook/shivered
__d. had warm perspiration
__e. had cold perspiration
__f. laughed
__g. yelled/shouted
__h. pounded fist/gestured angrily
__i. yawned/stretched
__j. tried not to think about it
__k. remembered good times
__l. remembered bad times
__m. asked questions
__n. other _____

3. How much did you feel each of the following in relation to the person who died when you were alone? Again, use a number from 1 to 7, where 1 represents not feeling it at all and 7 represents feeling it a great deal.

__a. anger
__b. hurt
__c. embarrassment
__d. relief
__e. guilt
__f. boredom
__g. fear/scared
__h. hopelessness
__i. disbelief
__j. depression
__k. anxiety
__l. acceptance
__m. other _____

4. How many times during the first two weeks did you:

__a. Visit your physician's office
__b. Call your physician's office
__c. Receive other medical service (explain)
__d. Feel physically ill, but seek no professional treatment
__e. Visit your minister
__f. Visit a counselor

5. Did anyone give you medication to help you deal with your loss? Yes ___ No ___ If you know them, please list the name of these medications.

NUMBER_____

Describe the times from two weeks to three months after the death when you were alone and thought about your loss.

1. On the average, how much total time did these thoughts occupy each week? _____

2. Indicate how much you did each of the following during times you were alone and thought about your loss. Use a number from 1 to 7, where 1 represents not doing it at all and 7 represents doing it a great deal.

__a. cried
__b. sobbed
__c. trembled/shook/shivered
__d. had warm perspiration
__e. had cold perspiration
__f. laughed
__g. yelled/shouted
__h. pounded fist/gestured angrily
__i. yawned/stretched
__j. tried not to think about it
__k. remembered good times
__l. remembered bad times
__m. asked questions
__n. other _____

3. How much did you feel each of the following in relation to the person who dies when you were alone? Again, use a number from 1 to 7, where 1 represents not feeling it at all and 7 represents feeling it a great deal.

__a. anger
__b. hurt
__c. embarrassment
__d. relief
__e. guilty
__f. boredom
__g. fear/scared
__h. hopelessness
__i. disbelief
__j. depression
__k. anxiety
__l. acceptance
__m. other _____

4. Approximately how many times did you:

__a. Visit your physician's office
__b. Call your physician's office
__c. Receive other medical service (explain)
__d. Feel physically ill, but seek no professional treatment
__e. Visit your minister
__f. Visit a counselor

5. Did you take any medication to help you deal with your loss? Yes ___ No ___ If you know them, please list the name of these medications.

NUMBER_____

Describe the times from three months to six months after the death when you were alone and thought about your loss.

1. On the average, how much total time did these thoughts occupy each week? _____

2. Indicate how much you did each of the following during times you were alone and thought about your loss. Use a number from 1 to 7, where 1 represents not doing it at all and 7 represents doing it a great deal.

__a. cried
__b. sobbed
__c. trembled/shook/shivered
__d. had warm perspiration
__e. had cold perspiration
__f. laughed
__g. yelled/shouted
__h. pounded fist/gestured angrily
__i. yawned/stretched
__j. tried not to think about it
__k. remembered good times
__l. remembered bad times
__m. asked questions
__n. other _____

3. How much did you feel each of the following in relation to the person who died when you were alone? Again, use a number from 1 to 7, where 1 represents not feeling it at all and 7 represents feeling it a great deal.

__a. anger
__b. hurt
__c. embarrassment
__d. relief
__e. guilty
__f. boredom
__g. fear/scared
__h. hopelessness
__i. disbelief
__j. depression
__k. anxiety
__l. acceptance
__m. other _____

4. Approximately how many times did you:

__a. Visit your physician's office
__b. Call your physician's office
__c. Receive other medical service (explain)
__d. Feel physically ill, but seek no professional treatment
__e. Visit your minister
__f. Visit a counselor

5. Did you take any medication to help you deal with your loss? Yes _____ No _____ If you know them, please list the name of these medications.

NUMBER_____

Describe the times from six months to one year after the death when you were alone and thought about your loss.

1. On the average, how much total time did these thoughts occupy each week? _____

2. Indicate how much you did each of the following during times you were alone and thought about your loss. Use a number from 1 to 7, where 1 represents not doing it at all and 7 represents doing it a great deal.

__a. cried
__b. sobbed
__c. trembled/shook/shivered
__d. had warm perspiration
__e. had cold perspiration
__f. laughed
__g. yelled/shouted
__h. pounded fist/gestured angrily
__i. yawned/stretched
__j. tried not to think about it
__k. remembered good times
__l. remembered bad times
__m. asked questions
__n. Other _____

3. How much did you feel each of the following in relation to the person who died when you were alone? Again, use a number from 1 to 7, where 1 represents not feeling it at all and 7 represents feeling it a great deal.

__a. anger
__b. hurt
__c. embarrassment
__d. relief
__e. guilty
__f. boredom
__g. fear/scared
__h. hopelessness
__i. disbelief
__j. depression
__k. anxiety
__l. acceptance
__m. other _____

4. Approximately how many times did you:

__a. Visit your physician's office
__b. Call your physician's office
__c. Receive other medical service (explain)
__d. Feel physically ill, but seek no professional treatment
__e. Visit your minister
__f. Visit a counselor

5. Did you take any medication to help you deal with your loss? Yes ___ No ___ If you know them, please list the name of these medications.

APPENDIX B

OUTCOME SELF-REPORT FORM

In each set, mark the single statement which best describes you at the present time.

1. __I participate more than I used to in church activities.
__My relationship to my church has not changed recently.
__I participate less than I used to in church activities.
__I cannot make myself participate in church activities anymore.

2. __I have joined new clubs or accepted new responsibilities for club activities.
__I have not changed my participation in clubs or organized groups.
__I have let my attendance drop or have taken less responsibility for club activities.
__I have let my membership lapse in clubs or organized groups.

3. __I don't feel as though I have many friends.
__I don't see much of my old friends, but I have made some new friends.
__My friendships are very stable.
__I still see a lot of my old friends, but I've also made some new friends.

4. __I spend almost all my time by myself.
__I spend about 75% of my time by myself.
__I spend about 50% of my time by myself.
__I spend about 25% or less of my time by myself.

5. __I have recently learned some new skills.
__I am planning to learn some new skills.
__I continue to do the things I've always done.
__I have recently felt as though I can't do things I used to do.

6. __My performance at work has improved.
__My performance at work hasn't changed.
__My performance at work has declined somewhat.
__My performance at work has declined a lot.
__I am not employed.

7. __My work is the only thing that keeps me going.
__My work is one of the few important things in my life.
__My work is one of the many important things in my life.
__My work is no more important than other parts of my life.
__I am not employed.

8. __I work more than 40 hours a week.
__I work between 30 and 40 hours a week.

__I work between 20 and 30 hours a week.
__I work less than 20 hours a week.
__I am not employed.

9. __I have no financial problems.
__I have to be careful, but my financial situation is satisfactory.
__I often worry about my financial situation.
__I am in serious financial difficulty.

10. __It is too painful to think of the past.
__It hurts some to think of the past.
__Thinking of the past is more pleasant than unpleasant.
__It feels good to think of the past.

11. __I definitely feel pessimistic about the future.
__I prefer not to think about the future.
__I think the future will be OK.
__I enjoy making plans for the future.

12. __Most of the time I feel very happy.
__Most of the time I feel rather happy.
__Most of the time I feel rather sad.
__Most of the time I feel very sad.

13. I feel depressed:
__always
__sometimes
__seldom
__never

14. I feel lonely:
__always
__sometimes
__seldom
__never

15. __I feel much worse than I ever did before.
__I feel somewhat worse than I did before.
__I feel no differently than I did before.
__I feel better than I did before.

16. __I have not changed anything that was theirs since the death.
__I have disposed of everything that was theirs since the death.
__I can't bear to look at anything of theirs since the death.
__I kept some things that I enjoy seeing in my house.

17. __There are a lot of places and people I avoid because of the memories.
__There are a few places and people I avoid because of the memories.
__Sometimes I find myself surprised by the memories some places and people hold.
__I enjoy reminiscing around familiar places and people.

18. __I feel I am adjusting well to my loss.
__I am adjusting better than I expected to my loss.
__I am adjusting less than I expected to my loss.
__I feel I am adjusting poorly to my loss.

APPENDIX C

LIFE SATISFACTION INDEX

Here are some statements about life in general that people feel different ways about. Would you read each statement on the list and decide if you strongly agree, agree, disagree, or strongly disagree with it. Then put a check mark under the heading that describes your response. If you are not sure one way or the other, put a check mark in the space under "?". PLEASE BE SURE TO ANSWER EVERY QUESTION ON THE LIST.

	strongly agree	agree	?	disagree	strongly disagree
1. As time passes, things seem better than I thought they would be.	___	___	___	___	___
2. I have gotten more of the breaks in life than most people I know.	___	___	___	___	___
3. This is the dreariest time of my life.	___	___	___	___	___
4. I am just as happy as I was in my life.	___	___	___	___	___
5. My life could be happier than it is now.	___	___	___	___	___
6. These are the best years of my life.	___	___	___	___	___
7. Most of the things I do are boring or monotonous.	___	___	___	___	___
8. I expect some interesting and pleasant things to happen to me in the future.	___	___	___	___	___
9. The things I do are as interesting to me as they ever were.	___	___	___	___	___
10. I feel old and somewhat tired.	___	___	___	___	___
11. As I look back on my life, I am fairly well satisfied.	___	___	___	___	___

	strongly agree	agree	?	disagree	strongly disagree
12. I would not change my past life even if I could.	___	___	___	___	___
13. Compared to other people my age, I make a good appearance.	___	___	___	___	___
14. I have made plans for things I'll be doing a month or a year from now.	___	___	___	___	___
15. When I think back over my life, I didn't get most of the important things I wanted.	___	___	___	___	___
16. Compared to other people, I get down in the dumps too often.	___	___	___	___	___
17. I've gotten pretty much what I expected out of life.	___	___	___	___	___
18. In spite of what some people say, the lot of the average man is getting worse, not better.	___	___	___	___	___

APPENDIX D

HEALTH QUESTIONNAIRE

NUMBER_____

We are interested to learn as much as we can about your state of health since the death. In particular, we wish to know whether you have developed any new complaints or whether any old complaints have been bothering you more than usual during this time. On the next page you will see a list of complaints and symptoms, and we would like you to underline any item in this list ONLY if

____ this is a new complaint, which you have never had before, which has caused you considerable concern since the death;

OR IF

____ this is an old complaint, but it has been much more troublesome since the death.

You will see from the above statements that we DO NOT want you to underline an item if it refers only to a minor complaint which did not last very long and did not concern you very much, OR if the complaint is an old one which has not bothered you any more than usual since the death.

Complaints and Symptoms

(Remember to underline an item ONLY IF it is a new complaint which has caused you considerable concern since the death, OR IF it is an old complaint which has been much more troublesome since the death.)

1. Constipation
2. Sleeplessness
3. Asthma
4. Pains in the back
5. General nervousness
6. Swollen or painful joints.
7. High blood pressure
8. Difficulty in swallowing
9. Persistent fears
10. Marked loss of hair
11. Cold sores
12. Migraine
13. Headaches
14. Severe itching
15. Fainting spells
16. Palpitations
17. Shortness of breath
18. Stomach ulcers

19. Nightmares
20. Hay fever
21. Pains in the face
22. Frequency of urination
23. Convulsions (fits)
24. Heart failure
25. Hives
26. Indigestion
27. Diarrhea
28. Rheumatism
29. Repeated peculiar thoughts
30. Pains in the chest
31. Trembling
32. Excessive tiredness
33. Twitching
34. Dizziness
35. Blurred eyesight
36. Diabetes (increased blood sugar)
37. Skin rashes
38. Excessive appetite
39. Painful monthly periods
40. Goiter (swelling in the neck)
41. Feelings of panic
42. Colitis
43. Vomiting
44. Excessive sweating
45. Fear of nervous breakdown
46. General aching
47. Poor appetite
48. Frequent infections
49. Very heavy monthly periods
50. Cancerous growth

Before you leave these pages, please look again at any items you have underlined, and mark the item with a capital D if since the death you saw a doctor about this complaint for the first time.

Finally, look once more at any underlined items, and mark the item with a capital H if since the death you had to spend time in a hospital because of this complaint for the first time.

____ Please place an X here if you read these pages and found nothing that applies to you.

SOME FINAL QUESTIONS ABOUT YOUR HEALTH

The next pages contain statements which can be completed in several possible ways. Please read carefully the first part of each statement, and then look at each of the endings which we have suggested and decide which one is most true for you. Mark with a cross (X) the ending which you select.

1. Since the death my weight:
   ___ has increased enough to concern me.
   ___ has not changed enough to concern me.
   ___ has decreased enough to concern me.

2. (DO NOT answer this question if you have always been and still are a non-smoker.) Since the death, I have been smoking:
   ___ much less than before.
   ___ a little less than before.
   ___ about the same amount as before.
   ___ a little more than before.
   ___ much more than before.

3. Before the illness and death I had depressed moods:
   ___ hardly never.
   ___ from time to time, but never enough to concern me seriously.
   ___ so frequent or so severe that I was seriously concerned.
   ___ severe enough for me to see a doctor.
   ___ severe enough for me to be admitted to a hospital.

4. After the first 2 or 3 months following the death my mood has been:
   ___ about the same as before the death.
   ___ depressed to an extent I thought was reasonable under the circumstances.
   ___ more depressed than I thought was reasonable.
   ___ depressed enough to concern me.
   ___ bad enough for me to see a doctor about it.
   ___ bad enough for me to be admitted to a hospital.

5. Before the death I took sleeping pills, tranquilizers, or nerve pills
   ___ not at all.
   ___ occasionally.
   ___ regularly, but not enough to concern me.
   ___ so much that I was concerned about it.

6. Since the death I have taken sleeping pills, tranquilizers or nerve pills
   ___ not at all.
   ___ less than before.
   ___ about the same as before.
   ___ more than before, but not enough to concern me.
   ___ so much that I have been concerned about it.

7. Before the death I drank alcoholic beverages:
   ___ not at all.
   ___occasionally.
   ___ fairly regularly, but not enough to concern me.
   ___ so heavily that I was concerned about it.
   ___ so heavily that I needed special treatment.

8. Since the death I have drunk alcoholic beverages:
   ___ not at all.
   ___ less than before.
   ___ about the same as before.
   ___ more than before, but not enough to concern me.
   ___ so heavily that I have been concerned about it.
   ___ so heavily that I have needed special treatment.

9. Since the death my ability to do my work has been:
   ___ much better than before.
   ___ a little better than before.
   ___ the same as before.
   ___ a little less than before.
   ___ much less than before.

Are there any general comments you would like to make about your health during the past four months?

Would you like to make any comments about the questions we have asked you? Was there anything you did not understand?

Thank you for your co-operation.

APPENDIX E

SOCIAL READJUSTMENT RATING SCALE

For each numbered question:

1. Think back on the item event and decide if it happened to you and when it happened.
2. If the event in question did happen in any of the time periods, mark "yes" in the blank in the appropriate time period.
3. If the event in question did not happen in any of the time periods, mark "no" in the blank in the appropriate time period.
4. If the event has happened, think about the most recent time. If "0" means no adjustment and "9" means completely changing your life, indicate how much adjustment the most recent occurrence required for you, using a whole number between 0 and 9. Mark this under "adjustment then."
5. Under "adjustment now" indicate how much adjustment the most recent occurrence of the event requires for you now, with "0" indicating no adjustment and "9" indicating completely changing your life.

	0-4 mo. ago	4 mo.-1 yr. ago	2-3 yrs.ago	Adjustment then	Adjustment now
1. A lot more or a lot less trouble with the boss	___	___	___	___	___
2. A major change in sleeping habits	___	___	___	___	___
3. A major change in eating habits	___	___	___	___	___
4. A revision in your personal habits	___	___	___	___	___
5. A major change in your usual type and/or amount of recreation	___	___	___	___	___
6. A major change in your social activities	___	___	___	___	___
7. A major change in church activities	___	___	___	___	___
8. A major change in number of family get-togethers	___	___	___	___	___
9. A major change in financial state	___	___	___	___	___

	0-4 mo. ago	4 mo.-1 yr. ago	2-3 yrs.ago	Adjustment then	Adjustment now
10. In-law troubles	___	___	___	___	___
11. A major change in the number of arguments with spouse	___	___	___	___	___
12. Sexual difficulties	___	___	___	___	___

This part is similar to the preceding section, except that you are to indicate the number of times that an event happened in each of the appropriate time periods. Thus in the first four blanks, write either 0, 1, 2, 3, or 4+ to indicate the number of times the event happened in each time period.

	0-4mo. ago	4mo.-1 yr.ago	1-2 yrs.ago	2-3 yrs.ago	Adjustment then	Adjustment now
13. Major personal injury or illness	___	___	___	___	___	___
14. Lost a close family member by death	___	___	___	___	___	___
15. Experienced the death of a spouse	___	___	___	___	___	___
16. Experienced the death of a close friend	___	___	___	___	___	___
17. Gained a new family member in your home	___	___	___	___	___	___
18. Major change in the health or behavior of a family member	___	___	___	___	___	___
19. Change in residence	___	___	___	___	___	___
20. Experienced detention in jail or other institution	___	___	___	___	___	___
21. Been found guilty of minor violations of the law	___	___	___	___	___	___

	0-4mo. ago	4mo.-1 yr.ago	1-2 yrs.ago	2-3 yrs.ago	Adjustment then	Adjustment now
22. Undergone a major business readjustment	___	___	___	___	___	___
23. Married	___	___	___	___	___	___
24. Divorced	___	___	___	___	___	___
25. Had marital separation from mate	___	___	___	___	___	___
26. Had an outstanding personal achievement	___	___	___	___	___	___
27. Had a son or daughter leaving home	___	___	___	___	___	___
28. Retirement from work	___	___	___	___	___	___
29. Major change in working conditions or hours	___	___	___	___	___	___
30. Major change in responsibilities at work	___	___	___	___	___	___
31. Fired from work	___	___	___	___	___	___
32. Major change in living conditions	___	___	___	___	___	___
33. Spouse began or ceased working outside the home	___	___	___	___	___	___
34. Took on a mortgage great than $10,000	___	___	___	___	___	___
35. Took on a mortgage or loan less than $10,000	___	___	___	___	___	___
36. Experienced a foreclosure on a mortgage or loan	___	___	___	___	___	___

	0-4mo. ago	4mo.-1 yr.ago	1-2 yrs.ago	2-3 yrs.ago	Adjustment then	Adjustment now
37. Taken a vacation	___	___	___	___	___	___
38. Changed to a new school	___	___	___	___	___	___
39. Changed to a different line of work	___	___	___	___	___	___
40. Begun or ceased formal schooling	___	___	___	___	___	___
41. Had a marital reconciliation with your mate	___	___	___	___	___	___
42. Had a pregnancy or fathered a child	___	___	___	___	___	___

APPENDIX F

INTERVIEWER RATING FORM

Week of Bereavement _____
Number _____

1. During your visit how much did the bereaved:

	not at all	a little bit	some of the time	quite a lot	all the time
a. cry	___	___	___	___	___
b. sob	___	___	___	___	___
c. tremble/shake/shiver	___	___	___	___	___
d. have warm perspiration	___	___	___	___	___
e. have cold perspiration	___	___	___	___	___
f. talk reluctantly	___	___	___	___	___
g. talk excitedly	___	___	___	___	___
h. laughed	___	___	___	___	___
i. yell/shout	___	___	___	___	___
j. pound fist/gesture angrily	___	___	___	___	___
k. yawn/stretch	___	___	___	___	___
l. change the subject	___	___	___	___	___
m. describe good times	___	___	___	___	___
n. describe bad times	___	___	___	___	___
o. ask questions	___	___	___	___	___
p. seek advice	___	___	___	___	___
q. other_____	___	___	___	___	___

2. Current adjustment rating:

___ poorly adjusted, depressed, grieving, no progress
___ intermittently disturbed and depressed, little progress
___ tenuous adjustment, could be easily upset, moderage progress
___ good adjustment, much progress

3. What attitude did the bereaved appear to have toward their own discharge of emotion?

___ makes me feel good to let go
___ makes me feel guilty when I'm emotional
___ makes me feel weak when I'm emotional
___ makes me afraid of losing control when I'm emotional
___ makes me feel depressed that I'm still so emotional
___ makes me feel concerned that I haven't "let go" yet

4. Other descriptive comments about the visit:

APPENDIX G

CORRESPONDENCE WITH CLERGY

THE UNIVERSITY OF NORTH DAKOTA
Grand Forks 58201

Department of Psychology Telephone: (701) 777-3451

December 9, 1976

Dear Pastor:

You may remember my talking with you personally, at the sermon study group, or at the November ministerial society meeting. At that time you indicated you were willing to participate in assisting my research of the grief process. My committee has approved my proposal and I can now begin asking for referrals from you.

In order to understand now individuals deal with the immediate experience of grief, I need to meet with the bereaved within two weeks of their loss and have continued contact with them for four months. I would appreciate your offering participation in this project to anyone in your congregation who has been bereaved through the death of someone who had been living in their household. Each person will provide valuable information for the project, including several members of the same family. My only limitation is that those referred must be at least 21 years old.

Please use the following four points when explaining the study:

1. A student at the university is trying to find out what happens to people during periods of grief.
2. She would like to find out what things you find helpful or upsetting to you over the next four months.
3. You will be asked to keep a weekly record of your activities. At later times you will be asked to record your impressions of yourself in more general situations and to provide some information about yourself before the death.
4. If you are interested I'll give her your name and she will call you to set up a time to talk with you personally. (Or I'll set up a time to introduce her to you, and then she can talk with you personally.)

Since I am not offering counseling services, I am counting on you and your church community to continue to offer your loving concern to them.

This project is my dissertation research for my doctorate in psychology at the University of North Dakota and is being directed by Dr. J. Dennis Murray. I anticipate a need for referrals from you through next April, 1977; it requires quite a bit of information in order to have confidence in the conclusions we reach. I will be very pleased to talk with you individually, or with a group of pastors, about our results at the conclusion of the project. Hopefully this information will help us to better understand and meet the needs of the bereaved in the future.

To insure the confidentiality of individuals participating, I must ask that you not share the names of the bereaved you refer to me with other members of the congregation, unless you have their specific permission to do so.

Please remember that I need to have early contact with the bereaved. To make a referral you may call Dr. Murray or myself at the Psychology Department, 777-3451, between 9:00 a.m. and 3:00 p.m. If neither of us is available, please leave your name and number so that we may return your call. If you have any further questions or concerns, please feel free to call and ask me. I appreciate your co-operation in this very special area of study.

Sincerely,

Anne Metzger, M.A.

THE UNIVERSITY OF NORTH DAKOTA
Grand Forks 58201

Department of Psychology Telephone: (701) 777-3451

December 9, 1976

Dear Pastor:

I am initiating dissertation research for my doctorate in psychology at the University of North Dakota under the direction of Dr. J. Dennis Murray. I have chosen to study the process of grief in an attempt to learn what experiences are most helpful in resolving grief.

In order to understand how individuals deal with the immediate experience of grief, I need to meet with the bereaved within two weeks of their loss and have continued contact with them for four months. A number of local pastors have already agreed to ask newly bereaved individuals in their congregation if they are interested in assisting me. I am writing to ask if you, too, would be willing to issue this invitation to the bereaved in your church community.

I realize that you will have many questions about such a project. I will be calling you during the next two weeks to offer to talk at length about my study. If you prefer to call me, I may be reached at the Psychology Department, 777-3451. Please feel free to leave a message for me to return your call.

Sincerely,

Anne Metzger, M.A.

THE UNIVERSITY OF NORTH DAKOTA
Grand Forks 58201

Department of Psychology Telephone: (701) 777-3451

May 23, 1977

Dear Pastor:

I am writing to follow up my recent phone calls to all the clergy who expressed an interest in the grief project I began last winter. My original study is continuing and I am still actively seeking participants willing to talk with me during the first four months of their grief. As before, I would like to begin my contact with them by the end of their second week of bereavement.

The newer portion of my study involves talking with people who have had a grief at any time during the past year. We have begun the interviews for this part of the project, and I would appreciate your talking with members of your congregation about participating. I have had a number of phone calls as a result of a newspaper article, however, I need to at least double the number of volunteers I have right now. Any assistance you could add--such as your asking specific individuals, including a note about the project in a Sunday bulletin, or making a general announcement at church meetings--would be helpful. I've been very impressed with the eagerness of the individuals who have called to volunteer, many of whom express the feeling that now they are ready to talk about their experience. People who have lost a parent, spouse, sibling, or child are all appropriate referrals.

Barbara Benner, another doctoral student, will be helping with the research during the summer. If you would like to make a referral you may call her at 777-3451 (Psychology Department). I am on a full time placement this summer and will be difficult to reach during the day. However, if you ever want to leave a message I can return your call. Some individuals may prefer to call and make the referral themselves and ask any questions they might have. Thank you again for your interest and help.

Sincerely,

Anne Metzger, M.A.

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